Feasibility Analysis of Community First Choice in Colorado

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Executive Summary

The Affordable Care Act (ACA, PL 111-148) established the Community First Choice (CFC) State Plan option to encourage states to provide more Medicaid-funded community-based long-term services and supports (LTSS). States that adopt the option must add self-directed Personal Assistance Services (PAS) to their State Plans. Because CFC services are available in the State Plan, they are available to all Medicaid beneficiaries who meet institutional level of care; CFC services cannot be limited to individuals with certain diagnoses. In exchange for making these services widely available, states receive an additional six percentage points on their federal match. Instead of paying 50 cents on the dollar for the PAS it currently provides in waivers, Colorado would instead pay just 44 cents on the dollar. Continuing its long-standing commitment to providing community LTSS, the state of Colorado undertook a study to explore the feasibility of adopting CFC. To this end, the Colorado Department of Health Care Policy and Financing (HCPF) chose Mission Analytics Group, Inc. (Mission Analytics), through a competitive bidding process, to estimate the annual costs to the state General Fund of adopting CFC, and to study the policy implications of this option. Mission Analytics conducted the study reported here with the close cooperation of HCPF and the CFC Development and Implementation Council. To our knowledge, Colorado is the first state to estimate the costs of CFC at the level of detail this report provides.

Using data from Fiscal Year 2011-2012 supplied by HCPF, Mission Analytics built a model that estimates the annual costs of providing CFC services to four groups: individuals currently on waivers, individuals on waitlists for waivers, individuals currently receiving Long-Term Home Health (LTHH), and individuals who do not currently receive any form of Medicaid-funded LTSS. The model estimates the costs of adopting a set of PAS that HCPF considers to be under the required services category, and a broader set of services, which includes some optional CFC services recommended by the CFC Council. The set of services to be considered in the first two scenarios are Personal Care, Health Maintenance (as provided through the service delivery options Consumer Directed Attendant Support Services (CDASS) and In Home Support Services (IHSS) Homemaker, and Personal Emergency Response System. The Council recommendations include these services, plus Behavioral Management, Behavioral Therapies, Independent Living Skills Training (ILST), Non-Medical Transportation, and Respite. Mission Analytics modeled the cost of these two sets of services under different assumptions about the anticipated cost levels of clients on waitlists and the anticipated cost levels of other clients. Take-up rates for CFC services were based on the take-up rates for those services in current waivers, adjusted slightly to account for likely differences in take-up rates among individuals with different needs. The model also includes assumptions about the degree to which individuals using LTHH will use CFC services instead, as this substitution can reduce the overall cost of providing CFC.

For HCPF-recommended services, the *additional* yearly cost to the General Fund ranges from $46.7 million, assuming moderate cost levels ($133.9 million General Fund and Federal Fund (Total Funds)) to $64.5 million, assuming high cost levels ($174.6 million for Total Funds). The *total* yearly cost of these services to the General Fund ranges from $414.1 million, assuming moderate cost levels ($868.9 million for Total Funds) to $432.1 million, assuming high costs levels ($909.6 million for Total Funds).

For Council-recommend services, the *additional* yearly costs to the General Fund range from $59.2 million, assuming low cost levels ($166.8 million for Total Funds) to $79.2 million, assuming moderate cost levels ($212.3 million for Total Funds). The *total* yearly costs of these services to the General Fund ranges from $426.7 million ($901.7 million for Total Funds) to $446.7 million ($947.2 million for Total Funds).

These estimates must be interpreted with some caution, for several reasons. First, rates have increased by 8.26 percent since FY 2011-2012, meaning annual costs will be higher. Second, the model cannot capture savings that might result if individuals use waiver services less intensively. Third, the model cannot capture possible savings from a decrease in hospital visits, prescription medication use, or institutional care. Fourth, the state may choose to implement policy changes that could yield additional savings (e.g., limiting the duration of LTHH). For budgetary purposes HCPF will have to provide more detail than this financial model offers.

To implement CFC, Colorado will have to make a number of policy-related decisions. First, it should decide whether to include Health Maintenance as a distinct service (as the state of Oregon has done), and, if so, which parts of the state's Nurse Practice Act must be waived to remove the requirement for delegation of nursing tasks. Although Colorado currently includes health maintenance in both CDASS and IHSS, the majority of skilled care in Colorado is provided through LTHH. Including health maintenance as a separate activity helps defray some of the costs of CFC by providing an alternative to LTHH that is both less costly and eligible for the enhanced six percent federal match. Second, as required by the regulations governing CFC, Colorado will have to eliminate conflict of interest in the assessment and provision of services. To align more broadly with policy emerging from the Centers for Medicare and Medicaid Services (CMS), Colorado should eliminate (or safeguard against) all conflict in its Case Management Agency Systems; this includes separating assessment, case management, and service provision. Third, the state must implement a system for Continuous Quality Improvement. The state need not adopt a new system; rather, it can use the system it already has in place to monitor its 1915(c) home and community-based waiver programs, with modifications to reflect recent changes in CMS guidance. Fourth, Colorado must collect a range of data on CFC participants, including demographic characteristics and outcomes. To measure

outcomes, the state can use the Quality of Life survey tool it already uses for Money Follows the Person.

Fifth, to align with emerging CMS policy on the attributes of community settings, the state should ensure that the contexts in which it provides Medicaid-funded LTSS are integrated with the community and offer maximum choice and control. Finally, Colorado must decide which models of self-direction it wishes to offer under CFC: employer authority (the ability to select, train, manage, and dismiss attendants), budget authority (the use of an individual budget to purchase appropriate goods and services), or both. To make this decision, the state must take into account the options for self-direction it already provides under CDASS and IHSS. It must also consider a critical feature of CFC: The state cannot mandate training for individuals or for the attendants they employ directly – although the state can continue to require training for workers employed by agencies. The importance of training will help determine whether the state permits a flexible employment authority or whether it restricts this authority to the co-employment model in which agencies and individuals employ workers on a joint basis (also called "Agency with Choice").

To help Colorado navigate the complex policy decisions it must make, Mission Analytics recommends that the state seek in-depth technical assistance from a range of experts. While some of this expertise is freely available through CMS-sponsored resources, the state may wish to consider hiring individuals or groups for longer-term consulting engagements.

1 Introduction and Overview

Colorado has historically been a leader among states providing supportive services to people with all types of disabilities, enabling them to live in the least restrictive settings possible. Shortly after 1915(c) waivers became available in 1981, Colorado obtained approval for the second and sixth waivers granted by the Centers for Medicare and Medicaid Services (CMS), first for individuals with developmental disabilities and then for individuals who are elderly, blind, or disabled. In the early 1990s, Colorado became one of the first states to implement a single entry point (SEP) system, using a network of entities to determine eligibility for Medicaid and functional eligibility for most of its waivers. Today, Colorado is one of only three states to have a waiver that provides services to individuals with serious mental illness.

Despite its national leadership and continued innovation, Colorado has not opted to offer Personal Assistance Services (PAS) in its Medicaid State Plan. Instead, these services are available only through some of the state's 12 waivers. In addition, the state's two waivers for adults with intellectual and developmental disabilities have large wait lists, as do the waivers that serve children with autism, children with life-limiting illnesses, and medically fragile children with physical disabilities. Many of these individuals could benefit greatly from PAS provided through the State Plan, where they cannot be targeted to particular populations, restricted to individuals living in particular regions of the state, or subject to waitlists.

The Patient Protection and Affordable Care Act of 2010 (ACA, PL 111-148) offers states a financial incentive to provide PAS in their State Plans. The main objective of Community First Choice, or CFC, incorporated into the Social Security Act at Section 1915(k), is to help keep individuals out of institutions by providing them with the following supports, through hands-on assistance, supervision, or cueing:

- Activities of daily living (ADLs), such as bathing and dressing;
- Instrumental activities of daily living (IADLs), such as shopping and housekeeping; and
- Health-related tasks, which can be delegated or assigned by licensed healthcare professionals to be performed by an attendant (or performed without delegation if portions of the state's Nurse Practice Act are waived).

States also have the option under CFC to enable individuals to purchase "permissible services and supports," – including assistive technology – provided they address a need identified in the individual's service plan and they increase the individual's independence or substitute in whole or in part for human assistance. A key requirement of CFC is that individuals have the option to self-direct their services and supports.

As an incentive to encourage states to adopt CFC, the enabling legislation adds 6 percentage points to the state's federal medical assistance percentage (FMAP) in perpetuity. In exchange,

states must set up robust systems for providing self-directed PAS, monitor the quality of those services, and report to the Centers for Medicare and Medicaid Services (CMS) on a regular basis. To date, three states – California, Oregon, and Maryland –have had their CFC State Plan amendments approved by CMS.

If Colorado chooses to adopt CFC, many of the services that are currently delivered through waivers would become part of the State Plan. PAS would be available to all Medicaid-eligible individuals who meet institutional level of care. Individuals currently on waitlists would be able to receive at least some of the services they need. Moreover, recipients of CFC could self-direct their PAS. Among states that have adopted or are considering CFC, Colorado is unusual in that it currently offers PAS only in waivers, where the scope of self-direction is variable and somewhat limited. Adopting CFC will decrease the cost of serving individuals who receive PAS through waivers. Importantly, however, serving a larger number of individuals through the State Plan will increase the overall costs of providing PAS.

To help the state explore the feasibility of adopting CFC from a financial and policy perspective, Colorado's Department of Health Care Policy and Financing (HCPF) contracted with Mission Analytics Group, Inc. to assess the implications of adopting CFC under several different assumptions about the services offered, the expected costs of individuals using CFC services, and enrollments. This report describes findings from our cost modeling efforts; identifies key policy decisions the state must make before implementing CFC; and lays out a tentative timeline for adopting the new State Plan option. To our knowledge, Colorado is the first state to undertake the kind of cost analysis of CFC that we describe in this report.

Chapter 2 sets the context for this work by reviewing Colorado's efforts to provide community-based long-term services and supports (LTSS). Chapter 3 summarizes the key components of the Final Rule for CFC. Chapter 4 describes the model we have developed to estimate the costs of adopting CFC in Colorado. Chapter 5 identifies five policy issues that Colorado must incorporate into its decision-making about CFC: waiving sections of its Nurse Practice Act to permit certain health-related tasks to be carried out without delegation; establishing a conflict-free system of assessment, case management, and service provision; implementing a system for quality improvement; collecting outcomes data; and ensuring that its community settings comport with the characteristics that will shortly be published in the Final Rule for the 1915(i) State Plan option. Chapter 6 is dedicated to a complex policy issue – the Financial Management Services that support self-directed services and supports, including Agency with Choice and Fiscal/Employer Agents. Chapter 7 summarizes the major findings of the feasibility report and identifies next steps.

We use the remainder of this introduction to place Colorado's exploration of CFC into the broader context of its ongoing efforts to reform its system of community-based long-term

services and supports (LTSS). This context will help readers understand the role that CFC might play in these systems transformation efforts. As a set of first principles, Colorado is committed to the idea that individuals have a right to exercise choice and control over how they receive services; to have their needs addressed in an equitable, person-centered fashion; and to receive the right services at the right time in the right setting. Moreover, Colorado is committed to involving stakeholders throughout its redesign efforts so that individuals and families have as many opportunities as possible to help shape the process.

Section 1915(k)(3) of the Social Security Act stipulates that CFC State Plan amendments will not be approved unless the amendment has been developed "in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives." Colorado established a Developmental and Implementation Council – called simply the CFC Council – in the summer of 2012; the group has met monthly since September of 2012. It has actively considered the benefits and challenges of adopting CFC; discussed the regulatory and policy changes that CFC would require; and reviewed the financial projections for adopting CFC that Mission Analytics has developed in partnership with HCPF (see Chapter 4 for details). Colorado's CFC Council has arguably been one of the most active and engaged Development and Implementation Councils in the nation.

A Note on Person-Centered Language: The notion of person-centeredness has come to occupy a central place in discussions about how best to support individuals with disabilities who wish to remain in their communities among family and friends. With person-centered thinking and planning has come person-centered language, which places the person before the disability that he or she happens to have. In keeping with person-centered thinking and planning, we will therefore use person-centered language throughout this report. Wherever possible, we will use the term individual (or its plural), as in "individuals with mental illness," as this is the term that appears most frequently in federal language, including all rules (and proposed rules) governing community-based LTSS under Medicaid law. We will at times use other terms, including *consumer* and *client*. We use *consumer* primarily in Chapter 6 to describe services that individuals direct (by managing employees, for example, or by choosing which services to purchase out of a service budget). We do this in large part because the term *consumer-directed* is commonly used in the literature to describe such services. We use the term *client* in Chapter 4 and in Appendix E, both of which describe the cost model that estimates the costs of adopting CFC. In those cases, we use *client* instead of *individual* because the labels for groups of individuals would otherwise sound awkward (e.g., "waiver individuals") or be too lengthy (e.g., "individuals who receive LTHH").

In all cases, our intent is person-centered. The goal of the Community First Choice State Plan option is to give individuals as much choice and control as possible over their services. The goal of this report is to help the state of Colorado assess the feasibility of giving its citizens this choice and control.

2 Community LTSS in Colorado

In this chapter, we briefly review Colorado's existing system of Medicaid-funded LTSS. We also describe a series of programs, initiatives, and workgroups that share the goals underlying CFC: to help as many Coloradans as possible remain in the community, among family and friends.

2.1 Review of Existing Community LTSS

In this section we first describe Colorado's long-term home health (LTHH) benefit, which is a mandatory benefit under the State Plan. Next, we briefly review the set of existing waivers for adults and for children. We conclude this section by reviewing the three service delivery options that currently provide individuals the opportunity to self-direct personal assistance services (PAS): In-Home Support Services (IHSS), Consumer-Directed Supports and Services (CDASS), and Family Caregiver.

Long-Term Home Health. For Medicaid-eligible individuals who need intermittent assistance with home health tasks, LTHH provides services from a licensed and certified Home Health Agency. Home health services include Skilled Nursing (provided by a registered nurse or licensed practical nurse); Certified Nurse Aid (CNA) services; Physical Therapy; Occupational Therapy; and Speech/Language Therapy.

There are two types of home health services: 1) acute home health services, which are provided to clients who experience an acute health care need that requires skilled home health care; and 2) long-term home health, which is provided to clients who require ongoing home health services beyond the acute home health period. To be eligible for home health, individuals must require services to treat or ameliorate an illness, injury, or disability, and be unable to perform health-related tasks for themselves. Individuals must also require services that cannot appropriately or effectively be provided in an outpatient treatment office or clinic, or for which the client's residence is the best setting in which to meet the client's needs.

Waivers. Colorado currently maintains 12 waivers, seven for adults and five for children. The names and age ranges of the waivers are listed below. Appendix D provides more detail on the waivers, including the services they provide, level of care requirements, and enrollment caps. Waivers with waitlists are noted as such below:

- The waiver for **Persons with Brain Injury (BI)** provides services to individuals with a brain injury, aged 16 and older.
- The **Community Mental Health Supports (CMHS)** waiver provides services to individuals aged 18 and older who have been diagnosed with a major mental illness.
- The waiver for **Persons Living with AIDS (PLWA)** provides services to individuals of all ages with a diagnosis of Human Immunodeficiency Virus/Acquired Immune Deficiency

Syndrome (HIV/AIDS).

- The waiver for Persons who are **Elderly, Blind and Disabled (EBD)** provides services to individuals aged 65 and older with a functional impairment, or to adults aged 18 through 64 who are blind or physically disabled.
- The waiver for **Persons with Spinal Cord Injury (SCI)** serves individuals aged 18 and older who have a spinal cord injury.
- The **Supported Living Services (SLS)** waiver provides services that help individuals aged 18 and older with developmental disabilities to live in their own home, apartment, family home, or rental unit that qualifies as an SLS setting. The waiver provides services as an alternative to institutional placement for individuals with developmental disabilities, but it does not provide 24-hour supervision. There is a waitlist.
- The **Comprehensive Waiver for Persons with Developmental Disabilities (DD)** provides services to individuals aged 18 and older who have a developmental disability and require access to 24-hour services and supports. There is a waitlist.
- The **Children's HCBS (CHCBS)** waiver provides services to medically fragile children aged birth through 17 who have a disability. There is a waitlist.
- The **Children with Autism (CWA)** waiver provides services to children aged birth through five who have a diagnosis of autism. There is a waitlist.
- The **Children's Extensive Support (CES)** waiver provides services to children aged birth through 17 who have a developmental delay or disability. To be eligible for CES, children must also have intensive behavioral or medical needs. There is a waitlist.
- The **Children's Habilitation Residential Program (CHRP)** waiver provides services to children and youth aged birth through 20 who are in foster care and who have a developmental disability and extraordinary needs.
- The waiver for **Children with a Life-Limiting Illness (CLLI)** provides services for children aged birth through 18 who have a life-limiting illness where death is probable before adulthood. There is a waitlist.

Under several waivers, individuals can choose to self-direct their PAS through In-Home Support Services (IHSS), through Consumer-Directed Attendant Services and Supports (CDASS), or through Family Caregiver.

Under the CHCBS waiver, IHSS offers Health Maintenance. Under the EBD and SCI waivers, IHSS also offers support for activities of daily living (ADLs) through Health Maintenance, Personal Care and Homemaker services. IHSS agencies provide core independent living skills, including Cross-Disability Peer Counseling; Information and Referral; Independent Living Skills Training; and Individual and Systems Advocacy. To receive IHSS, individuals must be eligible for a waiver that provides the service; they must demonstrate a need for attendant supports; and they (or their representatives) must demonstrate the ability to direct their care. In order to qualify as an

IHSS agency, an entity must offer independent living core services, provide 24-hour back-up services, and contract with or have on staff a health professional who will be responsible for the training of attendants. Attendants selected by clients are employed by an IHSS agency of their choice.

CDASS is a consumer-directed service delivery option that permits individuals to:

- Hire attendants, even friends and family, based on qualifications that they set;
- Train, supervise, and dismiss attendants;
- Decide when and where they receive services;
- Set wages for attendants, within an annual budget; and
- Choose someone they trust to act as an authorized representative to help them manage their care.

In CDASS, Medicaid funds are set aside for individuals to control, rather than paying a Home Health agency or Personal Care agency to provide their attendant care. The individual's case manager determines his or her individual annual allocation. After individuals (or their representatives) complete training and enroll in services, they are responsible for managing these funds to meet their needs. To receive CDASS, individuals must be eligible for a waiver that offers the service (EBD, CMHS or SCI); they must demonstrate a need for attendant supports; they must have a stable heatlh condition; and they must demonstrate the ability to direct their care.

Family Caregiver is an option available in Colorado's three waivers for individuals with developmental disabilities – CES, DD, and SLS. It permits individuals to receive services at home from a person of their choosing. Authorized in 2008 under Colorado's Family Caregiver Act (SB 08-002), this service delivery option allows individuals to live in their homes or in the homes of family members, and receive services from a family member or from staff or providers of a Program Approved Services Agency (PASA). Family Caregiver does not permit full employer authority or budget authority, and is therefore not a traditional self-directed program. However, the ability of individuals to choose family members as caregivers does represent a limited form of self-direction.

2.2 Related Programs, Initiatives, and Work Groups

Colorado's approach to transforming its LTSS system has been holistic, progressive, and supported at the highest levels of state government.

In June 2009, Governor Bill Ritter, Jr. issued an Executive Order (D 011-09) called “Directing the Development of a Strategic Plan to Promote Community Based Alternatives for the Disabled Citizens of Colorado." In the words of that Order:

> The State of Colorado rejects the institutionalization of individuals with disabilities when such institutionalization is not justified and has continued to serve as a national leader in providing service programs that expand and improve community-based alternatives for the disabled. Yet, 10 years after the Court's disposition in *Olmstead*, barriers still exist that impede the ability of the disabled to live and receive treatment in less restrictive environments. This Executive Order directs the development of a strategic plan that will promote the policies laid out in *Olmstead* by guarding against unjustifiable isolation and enhancing Colorado's ability to provide community-based treatment programs and facilities for the disabled.

The order directed the Long-Term Care Advisory Committee within HCPF to "review relevant state policies and bring together key stakeholders in order to develop a long-term strategy for improving access to community-based treatment programs and facilities for qualified individuals with disabilities."

In July 2010, HCPF met the mandate of this Order by releasing a report entitled "*Olmstead:* Recommendations and Policy Options for Colorado." In partnership with the Long Term Care Advisory Committee and a core team of stakeholders, the Department identified six key issues and strategies around community-based long-term care. These were to:

1. Make the financing of services in Colorado more sustainable, in part by re-examining reimbursement methodologies for providers;
2. Integrate policy decisions to improve access to community LTSS – that is, to look at programs and policies collectively, rather than in isolation;
3. To increase housing options for people with all types of disabilities;
4. To expand the current array of services, in part to diminish the gap between the services available to people in institutions and those available to people in the community, and in part to minimize cost shifting between systems, such as between the developmental disability system and the mental health system, as a result of services being available in one waiver but not in others;
5. To stabilize and grow the supply of direct service workers (DSWs), to reduce the kind of turnover in staffing that can increase the likelihood individuals will be placed in institutions; and
6. To better inform the community about the services available for people with disabilities.

In July 2012, Governor John W. Hickenlooper issued an Executive Order (2012-027) that accelerated the process of LTSS reform in Colorado. Echoing his predecessor's Executive Order, Governor Hickenlooper wrote:

> The State of Colorado recognizes that confining disabled individuals to isolation without proper cause is a form of discrimination. In order to preserve the quality of life for individuals afflicted with disabilities, the state shall promote and advance the availability of autonomous and independent community-based treatment programs and facilities.

The Governor's Order established the Office of Community Living (OCL) within HCPF. It directed the Office and its Director to "redesign all aspects of the long-term services and supports delivery system, including service models, payment structures and data systems to create efficient and person-centered community care." It further directed all relevant state agencies and divisions to coordinate with the Office. The guiding principles of the Office are to:

1. Provide services in a timely manner with respect and dignity;
2. Strengthen consumer choice in service provision;
3. Incorporate best practices in service delivery;
4. Encourage integrated home-and community-based service delivery;
5. Involve stakeholders in planning processes; and
6. Incorporate supportive housing.

The Order further mandated the creation of a Community Living Advisory Group with diverse membership and a mission to make legislative recommendations for 2013 and 2014, with final recommendations to the Governor by September 30, 2014. These will include recommendations about the structure and staffing of the OCL.

Most recently, in May of 2013, the two Houses of the Colorado General Assembly issued a Joint Resolution (HJR 13-1023) affirming the need for a redesign of Colorado's LTSS system to be based on the values of person-centeredness and self-direction.

Adult Resources for Care and Help (ARCH). Following the national model of Aging and Disability Resource Centers (ADRCs) established by the Administration on Aging (now the Administration for Community Living), Colorado has established the Adult Resources for Care and Help (ARCH) program. The mission of ARCH is to provide coordinated and streamlined access points to community LTSS for adults aged 60 and over, or aged 18 and over living with a disability, and their caregivers. ARCH empowers older adults, adults with disabilities, and caregivers to navigate health and LTSS options. Currently Colorado has 13 ARCH sites covering 52 of the state's 64 counties, ARCH sites are designed to streamline access to community LTSS for all individuals, not just those eligible for Medicaid. ARCH sites work collaboratively with community, state and federal programs to help people with disabilities and elders access supportive services that can enable them to live in the most integrated and independent setting possible.

Colorado Choice Transitions (CCT). Colorado Choice Transitions (CCT), part of the federal Money Follows the Person (MFP) Rebalancing Demonstration, is a five-year grant program. Launched in March of 2013, CCT's primary goal is to facilitate the transition of Medicaid beneficiaries from nursing homes or other long-term care facilities to the community. CCT services are intended to promote independence, improve the transition process, and support individuals in the community. CCT participants have access to qualified waiver services as well as demonstration services. They will be enrolled in the program for up to 365 days, after which time they will enroll into one of five HCBS waivers so long as they remain Medicaid eligible.

PACE. Colorado has adopted the national Program of All-Inclusive Care for the Elderly (PACE), a Medicare/Medicaid managed care program that provides health care and support services to individuals 55 years of age and older. The goal of PACE is to help frail individuals live in their communities as independently as possible by providing comprehensive services based upon their needs.

Family Caregiver Support Program. Colorado has also adopted the National Family Caregiver Support Program (NFCSP), which was created by the reauthorization of the Older Americans Act in 2000. The goal of the NFCSP is to provide services to caregivers who assist elderly adults, as well as grandparents over 60 raising grandchildren aged birth to 18.

Medicaid Buy-In. Since 2012, Colorado has offered two groups the option to "buy in" to Medicaid: working adults with disabilities, and families with children who have disabilities. The groundwork for these two options was laid by the federal Ticket to Work Incentives Improvement Act of 1999 (PL 106-170), and by two state laws, the Medicaid Buy-in Act of 2008 (HB 08-1072) and the Colorado Health Care Affordability Act of 2009 (HB 09-1293).

The Medicaid Adult Buy-In program launched on March 1, 2012. To be eligible, individuals must be between the ages of 16 and 64. All individuals are treated as a household of one (i.e., eligibility does not depend on the income or assets of any other individuals). While individuals must be working, there are no minimum wage or hour requirements. Individuals must have a qualified disability using the criteria of the Social Security Administration, without consideration of substantial gainful activity (SGA). In Colorado, working individuals with disabilities can earn up to 450 percent of the federal poverty level (FPL), after certain disregards. There are no resource limits, and premiums are set on a sliding scale based on income. On December 1, 2012, the Buy-In program was extended to give individuals with disabilities access to community LTSS outside the State Plan. To receive additional community LTSS benefits, individuals must meet the eligibility criteria for the standard adult Buy-In program; be at least 18 years old; and meet the functional and targeting criteria of the EBD or CMHS waivers. Colorado plans to explore the feasibility of expanding access to community LTSS to all adults in the Buy-In Program who have qualifying disabilities.

Launched on July 1, 2012, the Medicaid Buy-In Program for Children with Disabilities (Children's Buy-In) provides Medicaid benefits for children with disabilities whose adjusted family income is at or below 300 percent of FPL. There are two ways to determine eligibility for the Children's Buy-In: a disability determination through the Social Security Administration, or, if the child does not have such a determination, through the state's disability determination contractor. Eligible families receive Medicaid benefits for their child with a qualifying disability by paying a monthly premium on a sliding scale based on their adjusted income. The Children's Buy-In does not have a level of care requirement. Children on a waiver waitlist may qualify for the Children's Buy-In program if they meet all eligibility criteria. Children on the waitlist for the CES, CWA or CLLI waivers can remain on the waitlist and receive Medicaid benefits through the Children's Buy-In program while awaiting waiver enrollment.

Waiver Simplification. Colorado has recently undertaken a major effort to simplify its existing waiver system. As noted earlier, Colorado has 12 waivers, seven for adults and five for children. Over time, the system has become complex and confusing for individuals and families to navigate. Individuals and families must often make difficult choices among the service packages offered in different waivers. Several waivers have long waitlists, leaving many needy individuals and families without access to the services and supports they need to remain in the community or to help their loved ones remain independent. The administration of multiple waivers across several agencies has also created a burden for the state and consumed resources that could be spent on providing quality community-based care to a larger number of people.

In the summer of 2012, members of the Community Living Advisory Group established the Waiver Simplification Subcommittee and charged it with streamlining the state's waiver system. Since then the Subcommittee has met monthly. With input from many stakeholder groups, the Waiver Simplification Subcommittee has drafted a concept paper for CMS that outlines the state's tentative plans to combine some waivers and close others; to create one new waiver; and to move a number of existing waiver services into the State Plan. The process of waiver simplification is expected to take several years and require changes to service definitions, regulations, and policies and procedures. While the work of the Waiver Simplification Subcommittee is separate from the work of the Community First Choice Council, the Subcommittee has regularly discussed the ways in which CFC and the state's waiver simplification efforts might complement each other. Both CFC and a simplified set of waivers would help more individuals and families get essential community-based care in a person-centered system that more readily supports self-direction.

In the last seven years, two previous reports have affirmed the need for Colorado to add PAS to its State Plan. The first was the 2006 Final Report of the Senate Bill 05-173 Long-Term Care Advisory Committee (pursuant to §26-4-425 CRS). The second was the 2012 "Long-Term

Services and Supports Strategic Planning Report" prepared for HCPF by CHI Partners. Published two years after the passage of the Affordable Care Act, this report specifically recommended that Colorado consider adopting CFC.

As a prelude to the work that we describe in this report, we conducted a series of interviews with individuals, family members, and PAS attendants about the need for additional PAS. Our findings strongly suggest that there are still substantial unmet needs in the state – needs that CFC could help address. A detailed discussion of these interviews and focus groups, along with the questions that informed the discussion, can be found in Appendix C.

3 Summary of the CFC Rule

The CFC State Plan option was created by Section 2401 of the Affordable Care Act, which added Section 1915(k) to the Social Security Act. This chapter summarizes the key points of the Final Rule for CFC published in the Federal Register (77 FR 26828) and incorporated into the Code of Federal Regulations at 42 CFR 441.500-590. The text of the Final Rule is reproduced in full in Appendix A. Questions about the Final Rule that the Colorado Health Care Policy and Financing Administration (HCPF) has posed to the Centers for Medicare and Medicaid Services (CMS) can be found in Appendix B, along with CMS's answers to those questions. Our summary of the rule includes hyperlinks to the relevant sections of the Final Rule. It also includes references to the Preamble of the Final Rule, in which CMS responds to comments submitted in response to its preliminary rule, or Notice of Proposed Rule Making (NRPM). Because the Preamble is quite lengthy, we have not reproduced it here. Instead we provide references to the appropriate pages in the Federal Register.

3.1 Purpose

The purpose of CFC is to "make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing" (§441.500(b)). It grants states an additional 6 points of federal medical assistance percentage (FMAP) for eligible services (§441.590).

3.2 Eligibility

Individuals can qualify for CFC in one of two ways. First, they can belong to an eligibility group that has access to nursing facility services (§441.510(b)(1)). These groups include individuals who are enrolled waivers and individuals who participate in a Medicaid Buy-In program. Importantly, this provision does *not* require that the needs of a particular individual rise to nursing facility (NF) level of care. It means only that they belong to a *group* that has such access. For example, by virtue of being eligible for Medicaid State Plan services, members of the Buy-In group have access to NF services if they need them, but they need not require those services in order to be eligible for CFC. Second, individuals can have incomes at or below 150 percent of the federal poverty level (FPL) (§441.510(b)(2)).

All individuals who enroll in CFC must have an initial assessment. Except when individuals are not expected to improve, the state must perform annual reassessments to determine that "in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded" (§441.510(c)). Individuals who are eligible for Medicaid because they are enrolled in a waiver

must continue to meet waiver eligibility requirements and receive at least one waiver service a month (§441.510(d)). This lone service can include case management (p. 26842). Participation in CFC does not prevent individuals from receiving long-term services and supports (LTSS) through other authorities or grant programs (e.g., Money Follows the Person) (§441.510(e)).

States cannot limit the number of individuals who receive CFC services. In addition CFC services must be provided "without regard to the individual's age, type, or nature of disability, severity of disability, or the form of home and community-based attendant services and supports the individual requires to lead an independent life" (p. 26829). However, "states may set limits on the amount, duration, and scope of services, as long as the amount, duration, and scope are sufficient to reasonably achieve the purpose of the service" (p. 26833).

3.3 Services

States electing to adopt CFC *must* offer the following services (§441.520(a)):

- Assistance with activities of daily living (ADLs); instrumental activities of daily living (IADLs); and health-related tasks through hands-on assistance, supervision, and/or cueing;
- Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks;
- Backup systems or mechanisms to ensure continuity of services and supports; and
- Voluntary training on how to select, manage, and dismiss attendants.

Training on how to select, manage, and dismiss attendants cannot be required. States must offer the training, but they cannot require individuals to use training services, as doing so would not be consistent with the philosophy of self-direction (p. 26880).

States *may* also offer other services and supports that are "linked to an assessed need or goal in the individual's person-centered service plan" (§441.520(b)). These include:

- Expenditures for costs that help individuals transition from an institutional facility; and
- Expenditures for a need that "increases an individual's independence or substitutes for human assistance."

States may *not* offer the following (§441.525):

- Room and board unrelated to transition;
- Special education services covered under the Individuals with Disabilities Education Act (IDEA) or under the Rehabilitation Act of 1973;
- Assistive technologies other than those that form part of the backup system or substitute for human assistance; or

- Home modifications except those that facilitate transition or substitute for human assistance.

3.4 Assessment of Functional Need and Person-Centered Planning

States must conduct face-to-face assessments of individual "needs, strengths, preferences, and goals" (§441.535). The use of telemedicine is permitted provided individuals can choose an in-person assessment (§441.535(a)). The assessment information must support the following (§441.535(b)):

- The determination that an individual needs CFC;
- The development of a person-centered service plan; and
- The development of a service budget (if applicable).

Assessments of functional need must be conducted at least every 12 months. States must conduct them more often as an individual's needs change, or as the individual requests it (§441.535(c)).

To be person-centered, the planning process must have several key characteristics (§441.540(a)). For example, it must:

- Include people chosen by the individual;
- Be directed as much as possible by the individual;
- Reflect cultural preferences; and
- Offer the individual choice.

The plan itself must also have several key characteristics (§441.540(b)). For example, it must:

- Indicate that the setting in which the individual lives was his or her choice;
- Reflect the individual's strengths and weaknesses;
- Include "individually identified goals and desired outcomes";
- Identify the services and supports that will help the individual achieve these goals. These include natural supports. Notably, natural supports "cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant";
- Reflect risk factors and ways to minimize them; and
- Identify the individual or entity charged with monitoring the plan.

Like the functional assessment, the person-centered plan must be reviewed at least every 12 months. States must conduct them more often as an individual's needs change, or as the individual requests it.

3.5 Service Models

The Final Rule identifies several models for providing self-directed services under CFC.

Under the "agency-provider model" (§441.545(a)), individuals receive services from a traditional agency that employs personal attendants. Individuals must, however, have a meaningful say in the selection, management, and dismissal of their providers.

Under the "self-directed model with service budget" (§441.545(b)), the individual's service plan and budget are based on a functional assessment. States must make available a financial management entity (FME) to process timesheets, collect and file payroll taxes, track budgets, and perform other administrative functions (§441.545(b)(1)). States may also distribute cash directly and prospectively, provided the individual has the opportunity to use an FME for some or all administrative functions (§441.545(b)(2)). Individuals who cannot effectively manage their own budgets after counseling must be required to use these entities.

Individuals who use the service budget option are granted several types of authority (§441.550). For example, individuals have the authority to:

- Recruit, select, manage, and dismiss, attendants;
- Determine attendant duties, schedules, and training requirements;
- Evaluate attendant performance; and
- Determine pay rates, in accordance with state and federal laws.

Service budgets and the systems that surround them must meet a number of key requirements (§441.560). For example, they must:

- Identify a specific dollar amount for supports and services;
- Identify a set of procedures for how individuals may adjust their budgets;
- Identify the circumstances that would result in a change in the budget;
- Be objective, valid, and reliable;
- Be applied consistently;
- Identify limits on CFC services and the basis for those limits;
- Include safeguards to cover situations in which the budget does not meet an individual's needs; and
- Include procedures for adjusting the budget as an individual's needs change.

Under the "voucher" option (§441.545(c)), states may issue vouchers, provided other requirements in the rule are also met. States also have the option to provide services through other models if they are approved by CMS.

3.6 Support Systems

Support systems under CFC must meet several requirements. They must "appropriately assess and counsel an individual" before he or she enrolls (§441.555(a)), and provide necessary information, counseling, training, and assistance to manage services and budgets (if applicable).

Information must be communicated in a comprehensible manner, using auxiliary aids if needed (§441.555(b)(1)).

Support systems must have several key features (§441.555(b)(2)), including:

- A person-centered planning process;
- A range of options;
- Information about the "risks and responsibilities" of self-direction;
- Information about advocacy systems in the state;
- Methods to redress grievances and file appeals;
- Development of risk management strategies; and
- Registration and reporting of critical incidents.

Support systems must also establish "conflict of interest standards for the assessments of functional need and the person-centered service plan development process that applies to all individuals and entities, public or private." These requirements prohibit a range of individuals and entities from conducting the functional assessment and developing the person-centered service plan (§441.555(c)):

- Individuals related by blood or marriage to the individual or a paid caregiver;
- Individuals who are financially responsible for the individual;
- Individuals who can make health-related decisions on the individual's behalf;
- Individuals who would benefit financially from the provision of services identified in the assessment and planning process; and
- "Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process."

Thus, the Final Rule for CFC acknowledges that some areas of a state may offer fewer options than others. When the same entity both provides CFC services and performs functional assessment and service planning, the state must ensure that there are robust firewalls in place and that individuals have a straightforward way to dispute their service plans.

3.7 Provider Qualifications

Under all service delivery models, individuals can train attendants to best meet their needs; establish additional qualifications as needed; and access additional resources so that attendants can acquire necessary skills (§441.565(a)).

For the agency model, the state must define qualifications (§441.565(b)). For the self-directed model with service budget, individuals have the option to hire any individuals – including family members – to provide services, provided they meet qualifications and undergo additional training as needed (§441.565(c)). However, family members who provide services cannot simultaneously serve as the representatives for the individuals for whom they are working. Under these circumstances, an individual must have a representative who does not provide services (§441.505).

3.8 State Assurances

Any state that adopts CFC must agree to a set of assurances (§441.570):

- Protect the health and welfare of participants;
- For 12 months, maintain the level of expenditures for community LTSS provided under Sections 1115, 1905(a), and 1915 (i.e., waivers, State Plan services, and State Plan options);
- Adhere to the provisions of the Fair Labor Standards Act of 1938; and
- Comply with state and federal laws governing income and payroll taxes, unemployment and worker's compensation insurance; maintenance of general liability; and standards of occupational safety.

The Maintenance of Effort (MOE) requirements apply specifically to PAS provided under Sections 1905(a), 1915, and 1115 of the Social Security Act. Thus, for 12 months, the state must maintain the level of its expenditures on PAS in the 12-month period prior to the start of CFC.

3.9 Development and Implementation Council

The state must establish a "Development and Implementation Council" (§441.575), the majority of which consists of individuals with disabilities, elderly individuals, and their representatives. The state must consult and collaborate with the Council in developing and implementing CFC.

3.10 Data Collection

For each fiscal year, the state must report a variety of data elements related to CFC (§441.580), including:

- The number of individuals projected to receive CFC services in the next fiscal year;
- The number of individuals who received CFC services in the previous fiscal year;
- Demographic information on CFC recipients, including employment status;

- Information on how many CFC recipients were served under other HCBS authorities; and
- Information on "the physical health and emotional health" of individuals.

3.11 Quality Assurance

The state must have in place a quality assurance system (§441.585) that continuously monitors health and welfare; reports and addresses suspected cases of neglect or abuse; measures outcomes; establishes standards for the training of providers and for addressing individual appeals; maximizes individual choice and control; and solicits and acts upon feedback from individuals, their representatives, and members of the community, including advocacy organizations.

4 Modeling the Costs of CFC

The cost model we have developed allows Colorado to estimate the effects of moving personal-assistance services (PAS) from waivers into CFC. In this section, we describe how the model works and provide estimates of what CFC will cost the Colorado General Fund under four scenarios that reflect different choices about:

- The set of PAS in CFC;
- Usage (cost) for waiver clients and for other clients;
- How the introduction of CFC will affect clients who currently use Long-Term Home Health (LTHH); and
- Take-up among other clients who will be newly eligible for some or all of the PAS offered under CFC.

Note that we will not review the details of the Excel workbook in which we have implemented the model, or how users interact with the workbook. Interested readers can consult Appendix E for details.

4.1 The Cost Model

Because CFC offers an enhanced Federal Medical Assistance Percentage (FMAP) of 6 percent for self-directed PAS, it will cost Colorado less to provide PAS to individuals who currently receive them through waivers (assuming that rates and services stay the same). Instead of receiving a 50 percent match services for these individuals, the state will receive a 56 percent match. In other words, rather than paying 50 cents on the dollar for PAS, Colorado will pay just 44 cents on the dollar. This will result in savings for the state. Importantly, however, CFC services will *also* be available to individuals currently enrolled in waivers that offer few or no CFC services. For example, if CDASS were included in CFC, this service delivery option would become available to individuals enrolled on the Supported Living Services (SLS) waiver, the Children's Extensive Supports (CES) waiver and the Children's HCBS (CHCBS) waiver. Because many existing waiver clients will have access to services that are currently unavailable to them, the overall cost to serve the current population of waiver clients will thus *increase* rather than decrease.

More broadly, PAS that are moved out of waivers and into CFC will be available to all Medicaid-eligible individuals who meet institutional level of care. Unlike waiver services, CFC services cannot be targeted to individuals with specific diagnoses or provided just in selected regions, and they cannot have enrollment caps. Making PAS widely available is a central motivation for adopting CFC, since providing supports for ADLs, IADLs, and health-related tasks can help individuals on waitlists remain in their communities without having to wait years (in some cases) for waiver slots to open up.

Another motivation for adopting CFC is to offer PAS to non-waiver clients who have sought support through LTHH, which is heavily medical in nature and less focused on ADLs and IADLs. Some share of individuals receiving LTHH will switch away from LTHH altogether and instead use just CFC services. To put it differently, they will "substitute" CFC for LTHH. Some LTHH clients will continue to receive LTHH alone. Still others will seek a mixture of LTHH and CFC. Whether adopting CFC increases or decreases the cost of serving LTHH clients depends on the degree to which LTHH clients use CFC instead of LTHH.

Finally, CFC will be open to entirely new clients – those who are not enrolled in a waiver, not on a waitlist, and not receiving LTHH. Serving these individuals will increase the overall cost of adopting CFC.

Exhibit 4-1 and Exhibit 4-2 present simplified versions of the math required to estimate the annual cost to the Colorado General Fund of adopting CFC. Exhibit 4-1 groups related costs/savings together into existing costs, savings, and new costs.

Exhibit 4-2 groups related costs/savings into waiver/waitlist clients, LTHH clients, and newly eligible clients. The two tables present different ways to conceptualize the same set of computations.

Exhibit 4-1: Simplified Math for Calculating Annual Cost of Adopting CFC: Costs and Savings

	Annual Costs/Savings to Colorado General Fund of Adopting CFC =
Existing Costs	+ Cost of Existing Waiver Clients
	+ Cost of Existing LTHH Clients
Savings	- Savings from Moving Waiver Services into CFC
	- Savings from LTHH Clients Using CFC Instead
New Costs	+ Cost of Waiver Clients Using CFC Services Previously Not Available to Them
	+ Cost of Waitlist Clients Who Will Use CFC Services
	+ Cost of LTHH Clients Using CFC

Exhibit 4-2: Simplified Math for Calculating Annual Cost of Adopting CFC: Existing and New Clients

	Annual Costs to Colorado of Adopting CFC =
Waiver/Waitlist Clients	+ Cost of Existing Waiver Clients
	- Savings from Moving Waiver Services to CFC
	+ Cost of Waiver Clients Previously Unable to Access CFC Services
	+ Cost of Waitlist Clients
LTHH Clients	+ Cost of LTHH Clients
	- Savings from LTHH Clients Using CFC Instead of LTHH
	+ Cost of LTHH Clients Using CFC In Addition to LTHH
Newly Eligible Clients	+ Cost of Non-Waiver, Non-Waitlist, Non-LTHH Clients

The model performs computations on two main types of data supplied by the Colorado Department of Health Care Policy and Financing (HCPF) for Fiscal Year 2011-2012: *counts* and *costs*.

Counts. The model contains counts of individuals who currently receive waiver services, along with counts of individuals on waitlists. The model assumes that all individuals who currently receive a given type of PAS will continue to receive that service if it is moved into the State Plan.

It is more complex to estimate costs for waitlist clients than it is to estimate costs for current waiver clients. Some clients who are on a waitlist for one waiver are already receiving services under another waiver; moreover, some individuals are on multiple waitlists. The model does not attempt to deal with these duplicate clients; all clients are treated as unique. In exchange, the model's structure is simpler, and its output is easier to interpret. While the *number* of waitlist clients for each waiver is known, the *take-up rates* for waitlist clients, are not known (i.e., we do not know the percentage of waitlist client who will use each CFC service). When a service is offered on a waiver, the model assumes that take-up rates for waitlist clients will be the same as take-up rates for waiver clients: If 10 percent of waiver clients use a given service, the model assumes that 10 percent of waitlist clients will also use that service. When a service is *not* offered on a waiver, the model uses a default take-up rate, or a take-up rate that is specific to that service.

The number of LTHH clients in the model is taken straightforwardly from the number of existing LTHH clients. As we will see shortly, the number of entirely new clients – clients not on a waiver, on a waitlist, or receiving LTHH – is an unknown, and must be specified. Take-up rates for LTHH clients are specified on a service-by-service basis, while take-up rates for entirely new clients are set to be the same as waiver and waitlist clients who will be newly eligible for PAS.

We provide more detail on take-up rates later in this chapter.

Costs. The model uses the costs of waiver clients on a service-by-service basis. Because some individuals do not use waiver services or LTHH for a full year, the model adjusts cost data so they represent a full 12 months of use. For example, if an individual in FY 2011-2012 used Personal Care for just 10 months, the model multiplies the cost of Personal Care for that client by a factor of 1.2 (12 divided by 10). In general these adjustments do not make a substantial difference, but they ensure that cost comparisons are based on the same units of time.

Conceptually, the model estimates costs of providing PAS to individuals in five groups. Individuals in the first three groups are enrolled in, or waiting for, a waiver. Individuals in the remaining groups are *not* enrolled in, or waiting for, a waiver. For the sake of consistency and clarity, we use the example of Personal Care when we define the groups below:

1. **Clients on waivers that offer a particular PAS** – for example, individuals enrolled in the Supported Living Services (SLS) waiver, which offers Personal Care;
2. **Clients on waitlists for waivers that offer a particular PAS** – for example, individuals on the waitlist for the Supported Living Services (SLS) waiver, which offers Personal Care;
3. **Clients enrolled in/waiting for waivers that do not offer a particular PAS**– for example, waiver and waitlist clients on the Children's HCBS (CHCBS) waiver, which does not offer Personal Care;
4. **LTHH clients**, who are known to meet institutional level of care but who are not on a waiver, and therefore do not have access to Personal Care or to any other PAS;
5. **Entirely new clients**, who meet institutional level of care but are not receiving any form of LTSS.

Groups 1, 2, and 3 are defined on a service-by-service basis, depending on which CFC services are offered on the waiver they are enrolled in or waiting for. Groups 4 and 5 are not defined in this way, because they do not have access to *any* CFC services. Depending on the service, waiver clients will sometimes be in Group 1 and sometimes be in Group 3. Waitlist clients will sometimes be Group 2 and sometimes in Group 3. In other words, for Groups 4 and 5, the particular services in question do not matter.

Using data on costs and counts as its foundation, the model requires us to answer a series of questions:

1) Which services will move into CFC? The model makes no initial assumptions about which services the state will choose to incorporate into CFC. Instead, it presents an array of services that can be turned "on" and "off" dynamically. When services are turned "on," the model performs the calculations described in Exhibit 4-1 and

Exhibit 4-2. Services that are turned "off" do not affect the costs of CFC (i.e., existing costs remain unchanged).

2) For each PAS that moves into the State Plan, what share of the service will be eligible for the enhanced match? Some services are actually bundles of sub-services. Some of those sub-services will qualify as CFC services, while others will not. The model assumes as a default that 100 percent of all services will be eligible for the enhanced match. But the model permits users to enter percentages less than 100. The smaller the share of a service eligible for CFC, the more it will cost Colorado to move that service into its State Plan.

3) How many entirely new clients will be eligible for CFC? The model makes no initial assumptions about the number of individuals who will be eligible for CFC but are not currently receiving Medicaid-funded LTSS. The model requires users to enter a value for this population. The number of entirely new clients – clients not on a waiver, on a waitlist, or receiving LTHH – can be set separately, depending on the state's assumptions about the size of this population. In the scenarios we present below, this number is set to 1500.

4) How will CFC change the services that LTHH clients use? The model makes no initial assumptions about how the introduction of CFC might change the array of services that current LTHH clients use. Some LTHH clients may use LTHH because it is the only community-based service available to them. If given the choice, these clients would switch entirely to CFC – they would substitute CFC for LTHH. The model thus requires us to specify the percentage of current LTHH clients who will continue to use LTHH. If we believe that 25 percent of LTHH clients will stop using LTHH, we set this percentage to 75 percent. Current LTHH clients will likely make use of multiple CFC services. The model thus allows us to specify the service-by-service take-up rates for LTHH clients. For example, we might specify that 5 percent will use Homemaker, 10 percent will use Personal Care, and so on.

Because some LTHH clients may wish to receive both LTHH and CFC services, the percentage of clients continuing to use LTHH and the percentage of clients using CFC can sum to more than 100. Moreover, because clients can receive multiple CFC services, the sum of percentages across CFC services can exceed the percentage of individuals who no longer receive LTHH. For those individuals who opt to continue receiving LTHH, the cost of LTHH will likely go down, because some of their needs will be met through CFC. The model makes no attempt to adjust these costs, largely because there is no evidence-based way to make these adjustments.

5) Among clients currently not on a waiver or waitlist that offers a particular PAS, what share will take-up those services under CFC? The model assumes that the share of waitlist clients who use a CFC service will be the same as the share of waiver clients who use that same service. For example, if 25 percent of clients on a waiver use Personal Care, the model assumes

that 25 percent of clients on the waitlist for that waiver will also use Personal Care. By contrast, the model makes no initial assumptions about take-up rates among clients for whom we have no comparison data – specifically, clients on waitlists for waivers that do not offer a given PAS; LTHH clients; and entirely new clients. Instead, the model requires us to specify a default take-up rate for these individuals. If we believe that, in general, 20 percent of all clients will take up services to which they previously had no access, we set this value to 20 percent. If we believe that take-up rates for some services will be higher or lower, we can set service-specific take-up values that override the default.

In practice, the model uses service-specific take-up rates calculated from the take-up rates of clients who already have access to those services through waivers. This is simply the number of waiver clients who use a service divided by the total number of clients in the waiver. More specifically, the model uses the *maximum* take-up rates across all waivers. For example, the maximum take-up rate for CDASS is 9 percent, in the EBD waiver. The maximum take-up rate for Homemaker is 47 percent, in the CES waiver. In most cases, we adjusted these rates upward slightly, in consultation with HCPF, to account for anticipated differences in the patterns of service use across populations. For example, because families whose children are on waivers may be more likely than adults on the EBD waiver to use CDASS, we increased the take-up rate for CDASS from 9 percent to 15 percent. Note that this take-up rate represents an average across the entire population of individuals who will be eligible for CDASS. Some groups of clients may have high take-up rates, while others may have lower take-up rates.

For Independent Living Skills Training (ILST), which is offered only on the Brain Injury (BI) waiver, we adjusted the take-up rate *downward* from 40 percent to 10 percent. We made this adjustment for two reasons. First, ILST would likely be used less often by the eligible population as a whole than by individuals on the BI waiver. Second, ILST is a costly service, and using the take-up rate for ILST in the BI waiver would dramatically inflate the cost estimates for the Council recommendations.

We set take-up rates for LTHH clients separately, in consultation with HCPF.

6) What is the estimated level of cost for clients waiting to enroll in a waiver that offers a given CFC service? By definition, there are no cost data on waitlist clients. The model makes no initial assumptions about the level of need among waitlist clients compared to waiver clients. Instead, it allows us to specify the level of need (cost) as the *mean* (the average), the *median* (the mid-point), or the *25th percentile*. The mean is the best choice if we believe that costs are normally distributed (i.e., in the style of a bell curve). The median is the best choice if we believe that the mean might be distorted (skewed) by a small number of individuals with high levels of need (and therefore high costs). (It is for this reason that home prices are often reported as medians rather than means – so that a small number of high-priced homes do not

mislead us about the cost of a mid-priced home.) The 25th percentile is the best choice if we believe that waitlist clients are likely to have *lower* needs than most waiver clients, and would therefore have costs on the lower end of the spectrum.

Each of these options – mean, median, and 25th percentile – represents a different belief about the distribution of costs for waitlist clients. The choice of *median* indicates that we believe most waitlist clients fall within a range between "slightly higher than" and "slightly lower than" the client at the mid-point of the service for that waiver. The choice of *25th percentile* indicates that we believe that most waitlist clients fall within a range between "somewhat higher than" and "somewhat lower than" waiver clients at the 25th percentile for that service. These choices do *not* mean that all waitlist clients will have exactly that cost for the given service. Instead, they represent different beliefs about the "central tendency" of costs for waitlist clients for specific services.

7) What is the estimated level of cost for waiver and waitlist clients who do not have access to a given PAS? It is not possible to use the method described above to set the expected cost level of clients on waivers/waitlists that do not offer a given PAS. To accommodate these cases, the model looks across waivers that *do* offer that service. In order to set costs, the model requires us to choose among three options: *maximum* (the most expensive waiver offering that service), *minimum* (the least expensive waiver offering that service), or *mean* (the average cost across all waivers that offer that service). Note that these values are derived on a service-by-service basis, not for the waiver as a whole. Thus, "minimum" selects the lowest cost for a given service across waivers, not the waiver that is lowest-cost overall.

8) What is the estimated level of cost for LTHH clients and for entirely new clients? The model takes a similar approach to estimate the costs of non-waiver, non-waitlist clients. For LTHH clients and for newly eligible clients, we must again select a level of cost relative to the set of waivers that offer a given service. Again the model gives us three options: *maximum*, *minimum*, and *mean*.

Exhibit 4-3 presents a matrix of candidate services and waivers, with indications of which services are currently offered in which waivers. The model allows all of these services to be turned "on" (i.e., included in the costs of adopting CFC). Note that CDASS and IHSS are listed with services, even though they are service delivery options for bundles of other services. In addition, data for the SCI waiver are excluded because it is new and no data were available for the 2011-2012 fiscal year.

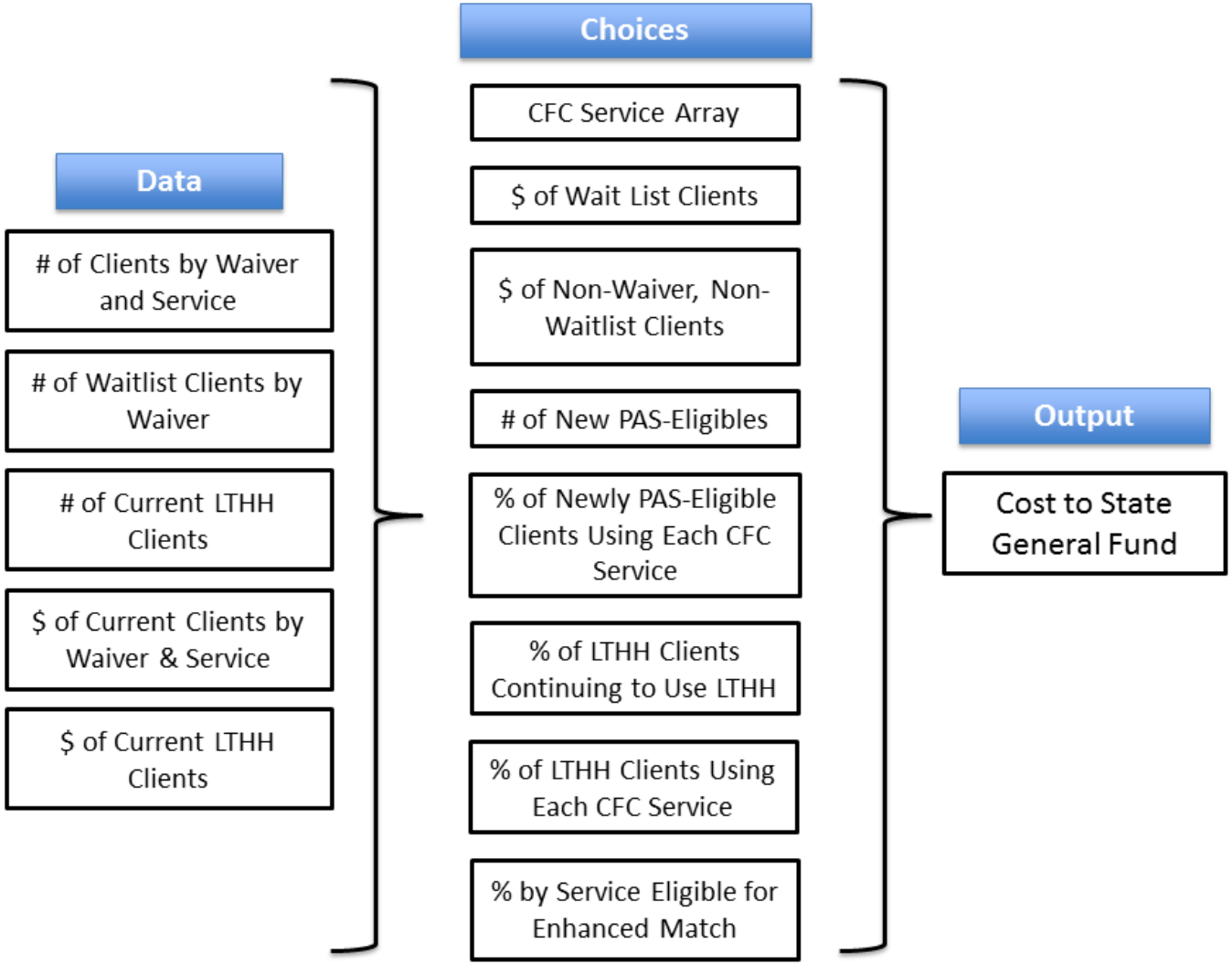
Exhibit 4-4 summarizes the inputs (data), assumptions (choices), and output (costs) from the model.

Exhibit 4-3: Candidate CFC Services by Waiver

Service or Service Delivery Option	CHCBS	CWA	CES	CHRP	BI	CMHS	PLWA	EBD	SLS	DD	CII
Behavioral Management					●				●	●	
Behavioral Therapies		●							●	●	
CDASS						●		●			
Homemaker			●			●	●	●	●		
IHSS	●							●			
Independent Living Skills Training (ILST)					●						
Mental Health Counseling					●						
Non-Medical Transportation					●	●	●	●	●	●	
Personal Care			●		●	●	●	●	●		
Personal Emergency Response Systems (PERS)					●	●	●	●	●		
Respite			●		●	●		●	●		●

Note: SCI waiver not included because no data were available for FY 2011-2012.

Exhibit 4-4: Inputs, Assumptions, and Outputs of CFC Cost Model



4.2 Projected Costs of Adopting CFC in Colorado under Different Scenarios

Exhibit 4-5 presents the four scenarios we used to estimate the costs of adopting CFC in Colorado. The scenarios differ in terms of the services they include and the level of costs they assume for waitlist clients and for clients who currently do not have access to a given service (here labeled "Other Clients"). Scenarios 1 and 2 include services recommended by HCPF. Scenarios 3 and 4 include the services in Scenarios 1 and 2, plus services recommended by the CFC Council. Scenario 1 assumes high cost levels; Scenario 2 assumes moderate-to-high cost levels; Scenario 3 assumes moderate-to-low cost levels; and Scenario 4 assumes low cost levels.

All four scenarios share the same assumptions about service take-up rates and about the degree to which LTHH clients will use CFC services in place of, or in addition to, LTHH.

Exhibit 4-5: Summary of Cost Levels, Services, and Take-up Rates for Four Scenarios

		Scenario 1: HCPF Recommendations: High Cost Levels	Scenario 2: HCPF Recommendations: Moderate/High Cost Levels	Scenario 3: Council Recommendations: Moderate Cost Levels	Scenario 4: Council Recommendations: Moderate/Low Cost Levels		Take-up Rates: Maximum of Historical + 3%- 6%	Percentage LTHH Population Using Service
Cost Levels	**Anticipated Cost of Wait List Clients**	Mean of Waiver	Median of Waiver	Median of Waiver	Median of Waiver			
	Anticipated Cost of Other Clients	Max Across Waivers	Max Across Waivers	Mean Across Waivers	Min Across Waivers			
Services	**Behavioral Management**			●	●		1%	0%
	Behavioral Therapies			●	●		20%	0%
	CDASS	●	●	●	●		15%	2%
	Homemaker	●	●	●	●		50%	5%
	IHSS	●	●	●	●		10%	1%
	ILST			●	●		10%*	0%
	LTHH							90%
	Mental Health Counseling			●	●		5%	0%
	Non-Medical Transportation			●	●		50%	0%
	Personal Care	●	●	●	●		50%	5%
	PERS	●	●	●	●		45%	0%
	Respite			●	●		40%	2%
Annual Cost to General Fund		**$64,572,448**	**$46,682,864**	**$79,237,230**	**$59,220,057**			

Notes:

All scenarios assume the addition of 1500 entirely new clients (non-waiver, non-waitlist, non-LTHH clients).

ILST is currently offered on just one waiver (Brain Injury), where the take-up rate is 40%. The take-up rate for the model has been adjusted downward to 10%.

Exhibit 4-6 presents the model's cost projections for the four populations that would be served by CFC: current waiver clients, LTHH clients, waitlist clients, and newly eligible clients. Costs for LTHH clients are broken out to reflect the costs of LTHH clients continuing to receive LTHH and the costs of LTHH clients who use CFC services in place of LTHH.

For HCPF-recommended services, the *additional* yearly cost to the General Fund ranges from $46.7 million, assuming moderate cost levels ($133.9 million for Total Funds) to $64.5 million, assuming high cost levels ($174.6 million for Total Funds). The *total* yearly cost of these services to the General Fund ranges from $414.1 million, assuming moderate cost levels ($868.9 million for Total Funds) to $432.1 million, assuming high costs levels ($909.6 million for Total Funds).

For Council-recommend services, the *additional* yearly costs to the General Fund range from $59.2 million, assuming low cost levels ($166.8 million for Total Funds) to $79.2 million, assuming moderate cost levels ($212.3 million for Total Funds). The *total* yearly costs of these services to the General Fund ranges from $426.7 million ($901.7 million for Total Funds) to $446.7 million ($947.2 million for Total Funds).

Exhibit 4-6: Summary of Annual Costs Under Four Scenarios Described in Text

Annual Costs	Scenario 1: HCPF Recommendations: High Cost Levels		Scenario 2: HCPF Recommendations: Moderate Cost Levels		Scenario 3: Council Recommendations: Moderate Cost Levels		Scenario 4: Council Recommendations: Low Cost Levels	
	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds
Waiver Clients (Waiver + CFC)	$341,746,981	$720,338,031	$331,090,940	$696,119,756	$357,831,820	$761,223,842	$345,891,113	$734,085,871
LTHH Clients (LTHH Only)	$58,718,829	$117,437,658	$58,718,829	$117,437,658	$58,718,829	$117,437,658	$58,718,829	$117,437,658
LTHH Clients (CFC)	$4,608,974	$10,474,941	$3,549,216	$8,066,400	$2,823,784	$6,417,692	$1,776,742	$4,038,051
Waitlist Clients (CFC)	$16,575,326	$37,671,195	$12,799,264	$29,089,235	$17,482,397	$39,732,720	$13,472,715	$30,619,808
Newly Eligible Clients (CFC)	$10,401,273	$23,639,257	$8,003,550	$18,189,888	$9,859,334	$22,407,577	$6,839,593	$15,544,527
Total under CFC	$432,051,383	$909,561,082	$414,161,799	$868,902,937	$446,716,164	$947,219,489	$426,698,992	$901,725,915
Current Total	$367,478,935	$734,957,870	$367,478,935	$734,957,870	$367,478,935	$734,957,870	$367,478,935	$734,957,870
Additional Cost	**$64,572,448**	**174,603,212**	**$46,682,864**	**$133,945,067**	**$79,237,229**	**$212,261,619**	**$59,220,057**	**$166,768,045**

4.3 Caveats in Interpreting Cost Projections

It is essential to consider several facts that warrant caution as we interpret these estimates.

As noted above, the cost data supplied by HCPF are based on claims and rates data from Fiscal Year 2011-2012. Rates have in fact increased since then by 8.26 percent. Moreover, with the exception of LTHH, the model does not capture potential changes in utilization that will likely accompany CFC. Waiver clients who have access to certain PAS for the first time will likely decrease the use of waiver services they may no longer need, or need less intensively. These changes would reduce the overall cost of CFC. Changes in policy and rates could also affect the cost of CFC. For example, if individuals using LTHH were required to transition to Personal Care after 120 days (assuming continued need), rates for Personal Care could be increased.

The model does not capture at least three sources of potential savings that could result from adopting CFC. The first is a reduction in the cost of institutional care once individuals have transitioned out of nursing facilities and into the community, where CFC could provide them with the supports they need to avoid returning to an institution. The second is a reduction in the cost of hospitalizations that results when individuals living in the community are injured or become ill because they lack the proper supports. The third is a reduction in the cost of medications that may be used to mitigate behavioral problems when behavioral supports would be less restrictive and more appropriate. In general, the model in its current form cannot account for savings that might accrue to current State Plan services other than LTHH. To capture these potential savings, the model would have to be considerably more elaborate. It would also require making a set of assumptions that might be difficult to defend in the absence of reliable data on the extent of such savings.

As noted above, the model permits us to specify the share of a service that qualifies for the enhanced CFC match. All services that are turned "on" in the model are likely to be eligible for the full enhanced match. One service that will likely *not* be eligible for the full enhanced match is Residential Habilitation, which is a bundle of services, including Self-Advocacy Training, Cognitive Services, and Community Access (10 CCR 2505-10 §8.500.A.5). If at any point Colorado decides that it would like to move Residential Habilitation into CFC, it will have to conduct a time study to determine what share of the service is eligible for the additional six percent match. The larger the eligible share, the less it will cost the state to move the service into CFC; the smaller the eligible share, the more it will cost the state to move the service into CFC, where it will be available to everyone who meets institutional level of care.

The model we have built provides a level of flexibility and detail that we have not previously seen in the literature on community LTSS. Nonetheless, it lacks details that HCPF will need to provide to the General Assembly during its fiscal note season.

In sum, the figures we present should be treated as provisional and subject to change once HCPF begins assembling the data necessary for budgetary purposes.

5 Policy Decisions Related to CFC

In deciding whether and how to adopt CFC, Colorado must make policy decisions in six key areas: the provision of health maintenance and the delegation of nursing duties; the elimination of conflicts of interest; systems for quality improvement; systems for data collection; characteristics of the settings in which individuals receive community-based long-term services and supports (LTSS); and the design of self-directed service delivery options. This chapter considers the first five of these areas. Because of its complexity, we discuss service delivery options separately in the next chapter.

5.1 To Health Maintenance, Delegation, and Colorado's Nurse Practice Act and Nurse Aide Legislation

The cost model we presented in Chapter 4 assumes that no portion of Long-Term Home Health (LTHH) will be eligible for CFC. The model excludes LTHH because CMS has indicated that LTHH does not qualify for CFC, and that it expects that many individuals will receive both types of services. (See the question on LTHH in Appendix B.) Health Maintenance, a related service, is available under both Consumer-Directed Attendant Supports (CDASS) and In-Home Support Services (IHSS), where it is bundled into a package of services. As defined under IHSS and CDASS, Health Maintenance activities:

> are those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas and suppositories and wound care. (10 CCR 2505-10 §8551.5.D; 10 CCR 2505-10 §8.552.1)

Because CFC permits states to offer assistance with health-related tasks, CDASS and IHSS can move into the State Plan as bundles.

Notably, Oregon's approved CFC State Plan amendment (SPA) includes services that appear similar to Health Maintenance. This indicates that Colorado could offer Health Maintenance under CFC as a separate service. Oregon's CFC SPA states the following:

> The state will provide Long-term Care Community Nursing Services (CNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals living in their own home or a Foster Home. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities.

Oregon includes the following health-related tasks in its list of CFC services:

- Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare;
- Medication reviews;
- Collateral contact to the person-centered plan coordinator regarding the individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered plan; and
- Delegation of nursing tasks, within the requirements of Oregon's Nurse Practice Act, to an individual's caregivers so that caregivers can safely perform health related tasks.

Oregon also identifies a set of "triggers" that may lead to a referral to Community Nursing Services, including "unexpected increased use of emergency care, physician visits, or hospitalizations" and an "eligible individual who does not follow medical advice."

If Colorado chooses to pursue Health Maintenance as a separate CFC service, it will have to consider the implications for nursing, as it has already done for CDASS and IHSS.

Each state has a Nurse Practice Act (NPA), a set of laws that define the responsibilities of nurses along with their scope of practice – the range of their activities and services as well as their qualifications for practice. According to the American Nurses Association (ANA), NPAs "are intended to protect patients from harm as a result of unsafe or incompetent practice, or unqualified nurses" (ANA, 2012). NPAs in many states define the conditions under which nurses can delegate their duties to another person. In a joint statement on delegation, the ANA and the National Council of State Boards of Nursing (NCSBN) noted that a registered nurse (RN) "can direct another individual to do something that that person would not normally be allowed to do." Whenever nurses delegate, they retain ultimate responsibility for the welfare of the individual to whom care is being provided. In their joint statement, the ANA and NCSBN noted that the RN "assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcomes, abilities of the staff to whom the task is delegated, and the context of other patient needs" (ANA and NCSBN, 2005).

The principles of delegation are structured around the "five rights" below:

1. **The right task:** The decision of whether or not to delegate or assign is based upon the RN’s judgment concerning the condition of the individual, the competence of all members of the care team, and the degree of supervision RNs will have to provide.
2. **Under the right circumstances:** Whether a task should be treated as skilled (i.e., requiring a nurse) depends on several factors, including the individual's preferences; the individual's level of comfort with an aid or device; whether a treatment requires a prescription or specific kinds of equipment; and whether the individual faces certain

kinds of substantial risks at the time the task is carried out (e.g., from infection).

3. **To the right person:** RNs delegate only those tasks that they believe others can perform, given their knowledge and skills. RNs should also take into consideration cultural competence, overall experience, and familiarity with the setting in which the task is to be carried out.
4. **With the right directions and communication:** RNs communicate with CNAs clearly, accurately, completely, and in a way that is individualized to the person and situation. RNs verify with CNAs that they understand and accept both the delegation and the responsibility that accompanies it. Communication must be two-way: CNAs should have the opportunity to ask questions and to request that expectations be clarified.
5. **Under the right supervision and evaluation:** RNs take responsibility and accountability for the provision of nursing practice. RNs may delegate components of care but cannot delegate the functions of assessment, planning, evaluation, and nursing judgment. RNs ensure that there are mechanisms to verify that a delegated task has been completed and that they have the information necessary to evaluate the outcome.

Colorado's NPA defines the qualifications and responsibilities of a registered nurse or registered professional nurse (§12-38-102(11) CRS), along with those of a practical nurse, trained practical nurse, licensed vocational nurse, or licensed practical nurse (§12-38-103(8) CRS). It also spells out the penalties for unauthorized practice as a practical or professional nurse unless licensed (§12-38-123(2) CRS).

The state's NPA also defines nurse aide practice, which requires education, training, and skills for certification as a nurse aide (§12-38.1-102(5) CRS). The NPA prohibits a person who is not a CNA from performing the duties of a CNA. Sections of Colorado's NPA are waived for clients receiving CDASS (§25.5-6-1102(7) CRS) and IHSS (§25.5-6-1203(3) CRS). These waivers of the NPA allow attendants to provide both skilled and unskilled personal care tasks without requiring licensure.

If the state wishes to offer Health Maintenance separately from other services, Colorado's General Assembly may have to pass legislation waiving portions of the NPA specifically for this service. CMS has made it clear that states decide which portions of their NPAs to waive. Colorado can thus amend its NPA to permit attendants to perform certain Health Maintenance tasks without the need for delegation (see Appendix B).

We recommend that Colorado explore with CMS the possibility of providing Health Maintenance as a distinct service. For IHSS and CDASS, allocation data for Personal Care, Homemaker, and Health Maintenance are already available through the PPL web portal, used for prior authorization. If the state finds that these allocation data are insufficient, it may need to conduct a "time study" to determine the share of time that workers spend on Health

Maintenance and then set rates for Health Maintenance as a distinct activity. (Guidelines for conducting a time study can be found in Circular A-87 (Revised) published by the Office of Management and Budget). The necessary changes to billing procedures may impose a substantial burden on providers. Nonetheless, making Health Maintenance available as a distinct service might encourage individuals who receive LTHH to use an alternative service that would be eligible for an enhanced six percent federal match – and which may be less costly even without the enhanced match.

5.2 Conflict of Interest Standards

Section 441.555(c) of the Final Rule establishes conflict of interest standards for the operation of CFC. The entities or individuals who assess service recipients must not be related to the individual receiving services; be financially responsible for the individual; be empowered to make health-related decisions on his or her behalf; or benefit financially from providing services to that individual. Moreover, assessments cannot be performed by any party that provides services – or benefits financially from the provision of services – to the individual being assessed. Exceptions are permitted solely when the only available assessor also provides community-based LTSS, as is often the case in rural areas. To accommodate those cases, the state must devise "conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities" (§441.545). In other words, the state must put in place firewalls that minimize potential conflicts, along with clear procedures for resolving disputes.

Notably, CMS has introduced conflict of interest standards into several Medicaid programs, including the 1915(i) State Plan option and the Balancing Incentive Program.

The conflict of interest standards proposed for 1915(i) at §441.668(b) are virtually identical to those in the Final Rule for CFC at §441.555(c). The Preamble to the Notice of Proposed Rule Making (NPRM) for 1915(i) elaborates on the reasoning behind these standards:

> Conflicts can arise from incentives for either over- or under-utilization of services; subtle problems such as interest in retaining the individual as a client rather than promoting independence; or issues that focus on the convenience of the agent or service provider rather than being person-centered. Many of these conflicts of interest may not be conscious decisions on the part of individuals or entities responsible for the provision of services. To mitigate any explicit or implicit conflicts of interest, the independent agent must not be influenced by variations in available funding, either locally or from the State. The service plan must offer each individual all of the HCBS [home and community-based services] that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process. The

service plan must be based only on medical necessity (for example, needs-based criteria), not on available funding. (77 FR 26373)

The Preamble for 1915(i) also notes that these standards must reflect the principles of §1877 of the Social Security Act, which prohibits certain types of referrals for services when there is a financial relationship between the referring entity and the service provider. According to the Preamble for 1915(i), firewall policies can include "separating staff that perform assessments and develop plans of care from those that provide any of the services in the plan; and meaningful and accessible procedures for individuals and representatives to appeal to the State" (77 FR 26373).

CFC and the 1915(i) State Plan option both prohibit service providers and other parties with a conflict of interest from performing assessments. The Balancing Incentive Program goes a step further and prohibits case managers from providing services as well. Created by §10202 of the Affordable Care Act, the Balancing Incentive Program is a time-limited grant program that gives qualifying states an enhanced match on community LTSS in exchange for making three structural changes: adopting a Core Standardized Assessment instrument; creating a No Wrong Door/Single Entry Point system; and implementing Conflict-Free Case Management. (Because Colorado spends more than 50 percent of its Medicaid long-term care dollars on community-based LTSS, it does not qualify for the Program.)

The *Balancing Incentive Program Implementation Manual* (Kako et al., 2013) reflects CMS's most current position on what it means for a system to be "conflict-free," and how such conflict can be eliminated or minimized (where elimination is impossible). It is worth quoting extensively from the relevant chapter of the Manual. According to the Manual, a conflict-free system optimally includes the following design elements (p. 30):

1. Clinical or non-financial eligibility determination is separated from direct service provision. Case managers who are responsible for determining eligibility for services do so distinctly from the provision of services. In circumstances where there is overlap, appropriate firewalls are in place so that there is not an incentive to make individuals eligible for services to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. This separation applies to re-determinations as well as to initial determinations.
2. Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.
3. There is robust monitoring and oversight. A conflict-free case management system includes strong oversight and quality management to promote consumer direction, and

beneficiaries are clearly informed about their right to appeal decisions about plans of care, eligibility determination, and service delivery.

4. Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or state for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.
5. Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.
6. State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised, both through direct oversight and/or the use of contracted organizations that provide quality oversight on the state's behalf.
7. State quality management staff track and document consumer experiences with measures that capture the quality of care coordination and case management services.
8. In circumstances when one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls exist to mitigate risk of potential conflict.
9. Meaningful stakeholder engagement strategies are implemented, which include beneficiaries, family members, advocates, providers, state leadership, managed care organization leadership and case management staff.

The standards developed for the Balancing Incentive Program will inform CMS's judgments about the presence of a conflict in a state's Medicaid-funded LTSS as a whole, independent of whether the state participates in the Program.

The conflict-of-interest standards articulated in CFC, 1915(i), and the Balancing Incentive Program will pose a challenge for Colorado's Community-Centered Boards (CCBs) and Single Entry Points (SEPs), which often have conflicts of interest in assessment, case management, and service provision (CHI Partners, 2012). To comply with the requirements of CFC, we recommend that the state separate these activities by moving the assessment function to entities independent from CCBs and SEPs. We strongly recommend that Colorado work to separate the three functions of assessment, case management, and service provision, whether or not the state chooses to adopt CFC.

5.3 Quality Improvement

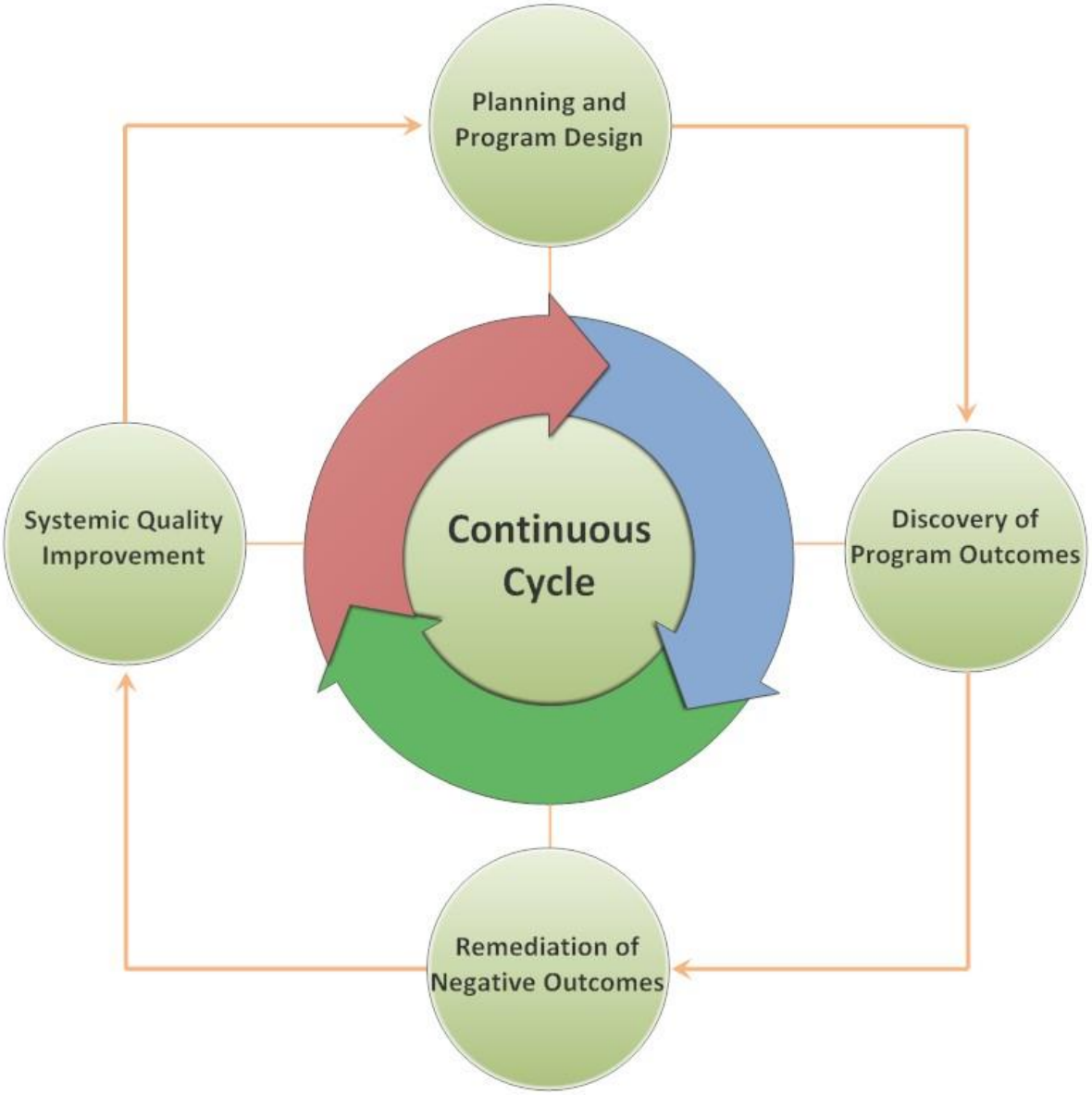
Following a report from the Government Accounting Office in 2003 that found minimal oversight of waiver quality (GAO-03-576), CMS used its statutory authority to require that states monitor and report on the quality of waiver services. In particular, CMS adopted an evidence-based approach that holds states accountable for the health and welfare of waiver

participants. The importance of quality has since been emphasized in other authorities, including HCBS State Plan options. In this section we briefly review those measures and discuss how Colorado can meet the quality requirements of CFC by building on its existing quality monitoring framework.

CMS requirements for quality have recently been updated. Working with the National Quality Enterprise (NQE) and state associations (the National Association of Medicaid Directors, the National Association of State Directors of Developmental Disabilities Services, and the National Association of State Units on Aging and Disability), CMS has revised its guidance to reduce the reporting burden on states and to focus on types of evidence that are most meaningful for measuring program quality. The review in this section draws both from the appendix to *Understanding Medicaid Home and Community Services* (Assistant Secretary for Planning and Evaluation, 2010) and from a presentation on the recent changes to waiver quality (Centers for Medicare and Medicaid Services, 2013).

CMS's evidence-based approach is built on a well-known management tool called Continuous Quality Improvement (CQI). CMS has adopted CQI in a cyclical model it calls Design, Discovery, Remediation, Improvement (DDRI). Exhibit 5-1 visualizes the DDRI model.

Exhibit 5-1: The DDRI Model



A state's CQI design is organized around a set of six federal assurances, each of which has subassurances. The assurances and some example subassurances are listed in Exhibit 4.1.

Exhibit 5-2: Assurance Types, Assurances, and Example Subassurances

Assurance Type	Assurance	Example Subassurance
Level of Care	The state demonstrates that it has designed and implemented the process and instrument(s) specified in the approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/IID.	An evaluation for LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.
Service Plan	The state demonstrates that it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.	Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
Qualified Providers	The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.	The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services.
Health and Welfare	The state demonstrates that it has designed and implemented an effective system for assuring waiver participant health and welfare.	The state demonstrates on an ongoing basis that it identifies and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
Financial Accountability	The state demonstrates that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.	The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
Administrative Authority	The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	No subassurances.

Design refers to a state's plan for how it will monitor a waiver program and make improvements when problems are detected. Version 3.5 of the waiver application (Centers for Medicare and Medicaid Services, 2008) requires a state to specify how it will discover that assurances have not been met; how it will remediate those problems; and how it will improve the performance of the system when widespread problems are discovered.

Discovery refers to the process of monitoring programs to detect deviations from program design in a timely manner. The discovery process requires states to identify a set of performance measures that enable it to assess whether and to what extent it complies with federal assurances. The state must specify at least one performance measure per subassurance. It must also describe its data sources; steps it will take to ensure the representativeness of a

sample; the agents responsible for collecting, reviewing, and using the data; and the frequency with which it will generate and review summary reports. Performance measures must:

- Be numerical (typically a percentage);
- Use the correct unit of analysis (e.g., waiver participant, provider agency, or provider);
- Accurately reflect the aspects of system performance they were designed to assess (i.e., have face validity); and
- Adequately represent the population (in cases where only a sample is used).

Remediation refers to the process states use to address problems revealed over the course of discovery. In their waiver applications, states must describe who is responsible for ensuring that problems are addressed; the timeframes for resolving problems; and the sanctions imposed when corrective actions are not taken. Like discovery data, remedial data must be numerical. The state must be able to aggregate the data to demonstrate that instances of non-compliance have been addressed.

Improvement focuses on making continuous adjustments to the overall system to improve discovery data. Improvements in discovery data indicate that the system overall has improved, which in turn means that less remediation is required. States can use a "pre-post" approach to gauge the success of remediation activities, by comparing data before improvement methods were put in place to data after such methods were used.

Under §441.485 of the Final Rule, states that adopt CFC must establish and maintain the comprehensive, continuous quality assurance system described in the State Plan amendment. At minimum that system must include:

1. A quality improvement strategy;
2. Methods to monitor the health and welfare of individuals;
3. Measures of individual outcomes associated with receiving community-based PAS; and
4. Standards across all service delivery models for trainings, appeals, and reconsiderations of an individual's person-centered plan.

Moreover, the state must ensure that its quality assurance system will maximize individual independence and control. The state must also inform individuals and families about its quality assurance system and use feedback from a variety of stakeholders to enhance its CQI efforts.

Ultimately the success of any quality assurance system depends crucially on the joint efforts of many parties:

- Individuals and families, by actively participating in the decisions that affect them and their loved ones;
- Provider agencies, by training and maintaining trained staff; by reporting reliably to the

state about the health and welfare of the individuals they serve; and by engaging in agency-level quality assurance activities;

- Assessors and service coordinators, by monitoring individual well-being; discovering and remediating problems at the level of the individual; and by reassessing individuals as their situations change; and
- The state, by establishing the policies, procedures, and tools to track and communicate information about the quality of its services; by remediating any systems-level problems; and by promoting continuous system-wide improvements.

Colorado has already developed a quality assurance system for its 1915(c) waivers. In part because the Division of Developmental Disabilities will be transferring from the Department of Human Services (DHS) to HCPF, the state is currently reviewing its system to streamline it and make it more robust. Once the state has completed its review and aligned its system with the changes recently announced by CMS (described above), it need not develop an entirely new system solely for recipients of CFC services. On the contrary, we recommend that the state use a system that is as uniform as possible across populations and authorities for providing community LTSS (i.e., waiver and State Plan). Adopting a uniform system will reduce the administrative burden on state staff, freeing up scarce dollars to expand services.

By establishing the CFC Council well in advance of deciding whether to adopt CFC, Colorado has already signaled that it takes the concerns of individuals and families seriously and is committed to including them in the process of developing, deploying, and improving CFC. We recommend that the state work closely with the Council to ensure that its strategies for CQI create a robust system that simultaneously builds on the work Colorado has already done and provides information that a range of stakeholders will find informative and empowering. In the words of the Preamble:

> States' quality assurance systems must also incorporate stakeholder feedback to improve the quality of the services offered under CFC. These aspects of CFC, along with the Development and Implementation Council, demonstrates the importance of the individual's perspective as it relates to services and supports provided under the program. (p. 26890)

5.4 Data Collection

Under §441.580, the CFC Final Rule requires that states collect a range of data elements about the PAS provided under the State Plan option. Some of these requirements are new for State Plans but have analogs in reporting that states must do for waivers (e.g., on the number of individuals served), while others are altogether new across all the authorities that support Medicaid-funded LTSS (e.g., reporting on program impact).

(Note that similar requirements appear under grant programs, including Money Follows the Person and the Balancing Incentive Program, but neither creates a permanent authority under Medicaid law.)

Under CFC, the following data must be collected and reported on an annual basis (note that the order of these items differs from their order in their Final Rule; to make discussion simpler, we have grouped similar items together):

1. An estimate of the number of individuals who will receive CFC services during the federal fiscal year;
2. The number of individuals who received CFC services during the preceding federal fiscal year;
3. The cost of providing CFC and other community LTSS;
4. The number of individuals receiving CFC who have previously been served under sections 1115 demonstration programs, 1915(c) waiver programs and 1915(i) State Plan options;
5. The characteristics of individuals who received CFC services by type of disability, age, gender, education level, and employment status;
6. The impact of CFC on the physical and emotional health of individuals;
7. How the state provides CFC and other community LTSS; and
8. How the state provides qualifying individuals with the option to receive community LTSS rather than institutional care.

In response to the concerns of some commenters that these reporting requirements would prove burdensome, CMS observes that it has implemented the requirements as specified in statute. Moreover, the agency notes:

> While some States may need to revise their data collection systems, we do not believe that this will affect all States. Additionally, since much of this data collection is also a requirement under other authorities, we believe that States have the mechanisms in place to gather the requested information for reporting without excessive additional burden. (p. 26896)

Colorado can report on data items (1) through (4) using administrative data that HCPF already records (or will record) using a combination of the Benefits Utilization System (BUS), which supports electronic case management activities; the Colorado Benefits Management System (CBMS), which manages eligibility for a variety of state programs; the Medicaid Management Information System (MMIS), which processes claims; and other databases, as appropriate.

Portions of data item (5) can be extracted from existing administrative data sets—specifically, age, gender, and type of disability, which should be available through the BUS, and

employment status, which should be available through the CBMS. Education level is likely to be more difficult, since it is not required to determine eligibility, and is only sometimes relevant for case management. The state will have to adapt existing tools and systems to capture educational information.

To report on data item (6), Colorado could adopt at least a portion of the National Core Indicators (NCI) tool. Developed by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Research Services Institute (HSRI), the NCI is a valid, reliable tool that includes approximately 100 consumer, family, systemic, cost, and health and safety outcomes. Data sources include consumer surveys (e.g., empowerment and choice issues) family surveys (e.g., satisfaction with supports), provider survey (e.g., staff turnover), and state systems data (e.g., expenditures, mortality, etc.). NASDDDS supplies technical assistance to support the use of the NCI, including training materials for interviewers. The NCI has been used primarily with individuals who have intellectual or developmental disabilities, but has recently been adapted for use with other populations. The Developmental Disabilities Division is already in the process of implementing the NCI for its three waiver programs.

Alternatively, Colorado could use the Money Follows the Person (MFP) Quality of Life Survey (QoL), which the state has already deployed as part of Colorado Choice Transitions (CCT), the state's name for its MFP program. Developed by Mathematica Policy Research (MPR), the national evaluator for the MFP demonstration program, the QoL Survey includes questions on a wide range of topics, including living situations; choice and control; access to personal care; respect and dignity; community integration and inclusion; life satisfaction; and health status. Colorado has already invested time and resources into preparing case managers to administer the survey. The QoL Survey is also supported by training materials developed by MPR. If Colorado chooses to adopt CFC, the QoL Survey will of course have to be administered to a much larger number of individuals than is currently the case. Nonetheless, because it captures all of the information necessary for data item (6), we recommend that Colorado use it for CFC.

CMS anticipates being able to collect data item (7) from information in the State Plan. The state can report data item (8) in several ways, including:

> a description of how the State provides individuals the choice to receive home and community-based services in lieu of institutional care, it could also include information regarding the methods used to offer this choice, the strategies involved in making this choice available, and the number of individuals that have made that choice. (p. 26886)

CMS plans to issue additional guidance on data collection under CFC (p. 26886); this guidance will probably come in the form of a State Medicaid Directors Letter (SMDL). CMS has not yet

indicated when it will issue this guidance. For now, states must proceed based on the guidance that appears in the Final Rule.

Whatever tools and systems Colorado chooses to satisfy the data collection requirements of CFC, we strongly recommend that HCPF consult with the CFC Council to determine whether there are additional data elements that might inform the way the state provides community LTSS, both within and beyond CFC. All parties should of course keep in mind the burden that data collection places on individuals and their families, as well as the administrative and financial costs that accompany data collection.

5.5 Community Setting

Over the last several years, CMS has worked to harmonize its requirements across the Medicaid authorities that provide community LTSS. As noted above, CMS has moved toward a more uniform system of quality management. It has also moved toward a more uniform definition of which settings count as "community." CMS's goal is to ensure that individuals live in settings that comport with the requirements of the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead* mandate to serve individuals in the most integrated, least restrictive setting possible.

In its Notice of Proposed Rule Making (NPRM) for CFC, released in February of 2011 (76 FR 10736), CMS indicated that its Final Rule would enumerate the attributes of true community settings. In May 2012, CMS released its NPRM for the 1915(i) State Plan option (77 FR 26362) in which the agency noted that it had received a large number of comments about its proposal in the NPRM for CFC. The volume of these comments, and the time required to give them proper consideration, prompted CMS to incorporate the characteristics of community settings into the NPRM for 1915(i). The Final Rule for CFC details the characteristics that CMS intends to include in the Final Rule for 1915(i), which is scheduled for publication in late 2013 or early 2014.

Because these requirements are likely to have widespread implications for Medicaid-funded LTSS, it is worth reviewing them as they are laid out in the proposed rule for 1915(i), which is referenced in the CFC Final Rule. While the Final Rule for 1915(i) may ultimately change some of the specifics, the category of "community settings" will closely resemble the one described in the proposed rule.

According to the proposed rule for 1915(i), a community setting:

- Is integrated into the wider community and gives individuals access to that community;
- Helps individuals seek work in competitive settings;
- Is selected by the individual and is identified in the person-centered plan;
- Protects an individual's rights to "privacy, dignity and respect, and freedom from coercion";

- Optimizes – and supports the flexibility of – individual choices in daily activities, physical environment, and interactions with other people; and
- Facilitates individual choices over the services and supports they receive and who provides them.

The Final Rule identifies several criteria that must be met in residential settings owned or controlled by providers:

- The unit or room where an individual lives is "a specific physical place" (p. 26854) that can be owned or rented, with the same responsibilities and protections that apply more generally under landlord-tenant law;
- Individuals have privacy in their sleeping or living units, with lockable doors to which only appropriate staff have keys;
- Individuals share their living space only if they choose to do so;
- Individuals can decorate their units, control their own schedules, have ready access to food, and can have visitors whenever they like; and
- The setting is physically accessible to individuals.

These conditions can be modified – for example, to support the needs of individuals with dementia – but only when those modifications support a specific need documented in the person-centered plan.

The CFC Final Rule proposes to exclude the following settings from the category of community settings:

- Nursing facilities;
- Institutions for mental diseases (IMDs);
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs); and
- Hospitals that provide long-term care services.

Crucially, the Final Rule notes that the Secretary of Health and Human Services "will apply a rebuttable presumption" that some settings are *not* community-based. In other words, CMS (as the Secretary's delegate) will initially assume that some settings do not comply with these requirements. Specifically, a setting will trigger "heightened scrutiny" if it is "located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex" (p. 26854).

As we noted earlier, CMS intends to apply these standards across its Medicaid-funded community LTSS programs. Therefore, whether or not Colorado ultimately chooses to adopt CFC, the state will ultimately have to ensure that the settings in which it provides community LTSS comply with the requirements that will appear in the 1915(i) Final Rule. We recommend

that the state perform a careful analysis of that rule when it appears. The state may wish to seek outside technical assistance to help it evaluate its current settings and, if necessary, develop a strategic plan for bringing into compliance all of the settings in which the state provides community LTSS.

6 Service Delivery Options under CFC

Because self-direction lies at the core of CFC, and because it is a complex topic, we have opted to review the topic in its own chapter. We begin by briefly reviewing the history of self-directed services. Next, we offer a general introduction to the different models of providing self-directed services, followed by a description of the delivery options currently available under the Colorado waivers that offer self-direction. We also review a recent Department of Labor (DOL) rule that establishes new requirements for the payment of minimum wage, overtime, and travel time to personal care workers.

Sections 5.1 to 5.3 draw from the excellent reviews presented in *Understanding Medicaid Home and Community Services: A Primer* (Office of the Assistant Secretary of Planning, 2010) and *Developing and Implementing Self-Direction Programs and Policies: A Handbook* (National Resource Center for Participant-Directed Services, 2010).

6.1 History of Self-Directed Services

Self-direction has a long history in the Medicaid program. Beginning in the early 1970s, a handful of states implemented personal attendant services (PAS) programs that authorized Medicaid participants to hire, train, supervise, and dismiss their workers. With the establishment of the §1915(c) home and community-based waiver program in 1981, interest in self-direction grew, as did support from the Centers for Medicare and Medicaid Services (CMS). In the mid-1990s, the Robert Wood Johnson Foundation (RWJF) collaborated with the Department of Health and Human Services (HHS) to pilot and evaluate the "Cash and Counseling" program. The Cash and Counseling demonstration program tested the feasibility of offering consumers an "individual budget," which they could use to purchase goods and services that met needs identified in their plan of supports. During this same period, RWJF also supported 1915(c) waiver programs that emphasized giving individuals and family members a leading role in developing person-centered plans. Along with a budget, individuals received independent counseling to help them choose and manage their services, and access to fiscal intermediaries to manage employment-related obligations such as payroll taxes. Following the success of these programs, and of the subsequent Independence Plus initiative (launched in 2002), CMS modified its waiver application materials to reaffirm and expand the agency's commitment to self-direction.

The Deficit Reduction Act of 2005 added two new State Plan options that permitted states to offer self-directed long-term services and supports (LTSS) without having to secure a waiver: §1915(j) "Cash and Counseling," and §1915(i) "State Plan Home and Community-Based Service." Section 1915(j) permits states to offer self-direction in their State Plan personal care services, as well as in any of their 1915(c) waivers. It does not permit states to add new services, but

instead creates a self-directed "overlay" for existing services. Section 1915(i) permits states to create a package of community LTSS with two key features: 1) individuals do not need to meet institutional level of care; and 2) eligibility for services is based on needs-based criteria. The Affordable Care Act of 2010 added a third feature to 1915(i): States may optionally target individuals by diagnosis and have multiple 1915(i) State Plan amendments. (States choosing to target by diagnosis must still specify needs-based criteria.) Although 1915(i) does not *require* states to provide self-direction, it expressly allows states to offer self-direction to program participants. The addition of the Community First Choice State Plan option under §1915(k) represents just the latest step in the evolution and spread of self-directed services throughout the Medicaid program.

6.2 Basic Features of Self-Direction in Medicaid LTSS

While each of the authorities described above has unique features, all of them – including CFC – share certain fundamental features.

Individual Election of Self-Direction: Any program that offers self-direction must offer *all* individuals the option to direct their own services. Some individuals will not choose this option, while others may begin by self-directing and then decide that it does not suit their needs and wishes. Moreover, the state may determine, even after providing additional support, that some individuals cannot successfully self-direct (if doing so jeopardizes their health and welfare, or the health and welfare of others). States must therefore make available traditional provider-managed options.

Participant-Led Service Planning Process: A long-standing right under Medicaid is the freedom of individuals to choose their providers. Self-directed programs must additionally help individuals or their representatives lead the person-centered planning process. Individuals must be free to choose who participates in the process with them (family, friends, providers, etc.).

Individual Authority over Service Delivery: Individuals who choose to self-direct can determine when and how they will receive services. Within the scope of services the state offers, and what has been approved in their individual supports plan, individuals may specify which services (or service elements) they will receive; when they will receive them; and specific qualifications for the workers and agencies that provide them.

Managing Workers: All self-directed service models, including CFC, allow participants to select, hire, train, supervise, and dismiss their workers. A state can choose between two basic models of *employer authority*: It may recognize individuals as the common-law employers of their workers and provide financial management entities (FMEs) to handle payroll taxes; or it may use a co-employer model in which an agency acts as a worker's legal employer (and thus handles payroll and reporting) while the individual manages that worker's day-to-day duties.

Individual Budget: Like other authorities that support self-direction, CFC permits states to provide individuals with budgets that include some or all of their support funding. With the aid of counselors and entities providing financial management services, individuals can purchase goods and services that meet needs identified in their plan of supports. This option is called *budget authority*.

General Supports for Self-Direction: Entities that provide financial management services (FMS) perform a range of services for individuals who self-direct, from collecting payroll taxes on workers (for individuals who exercise employer authority) to facilitating the purchase of goods and services (for individuals who exercise budget authority). FMS entities also track expenditures against individual budgets to help ensure that individuals do not prematurely deplete their budgets. States must also make available information and assistance (I&A) to help individuals learn about the range of services and supports available to them, acquire the expertise they need to manage their workers and their budgets, identify suitable providers, and access other benefits and community resources.

Safeguards: States must implement a range of safeguards to protect the health and welfare of individuals who self-direct. For example, systems must be put in place to help ease the transitions of individuals from self-directed services to traditional agency-provided services (and vice versa). The state must also work with individuals to establish individualized backup plans to minimize disruptions in service delivery (e.g., when a worker calls in sick).

6.3 Service Delivery Options

Under CFC, states choose the service models they intend to provide: the agency-provider model (employer authority), the self-directed model with service budget (budget authority), or both. Because these models play such a central role in the success of self-direction, we will describe them in additional detail.

Agency-Provider Model: Under the agency-provider model, "the entity either provides the services directly through their employees or arranges for the provision of services under the direction of the individual receiving services" (§441.545(a)(1)). In addition, "individuals maintain the ability to have a significant role in the selection and dismissal of the providers of their choice, for the delivery of their specific care, and for the services and supports identified in their person-centered service plan" (§441.545(a)(2)).

The self-directed agency-provider model that states most commonly use is called *Agency with Choice* (AwC). Under the AwC model, individuals and agencies act as "co-employers," with individuals choosing, training, managing, and dismissing their workers, while the agency serves as the "employer of record," managing payroll, taxes, insurance, and benefits. Roughly one-fifth of all self-directed service programs use AwC (NRCPDS, 2012).

The AwC model can offer advantages to both individuals and workers. Individuals have input into how their workers are chosen, trained, and managed without having to assume the administrative burdens of employing a worker directly. Workers can benefit from employment by a firm that, depending on its size, may be able to offer them attractive benefits such as a retirement plan.

Nonetheless, the AwC model carries risks for which states and individuals are not always prepared, largely because it creates ambiguity about the identity of the primary employer. Not all states recognize joint employment, so the model can only be implemented where it has an established legal status. At the federal level, joint employment is recognized by the Department of Labor under the Fair Labor Standards Act (FLSA) of 1938 (as amended), but it is not recognized by the Internal Revenue Service (IRS). These discrepancies create risks in several areas, including:

- The withholding, filing, and payment of payroll taxes (federal, state, and local);
- The withholding, filing, and payment of unemployment taxes;
- Workplace safety and workers' compensation; and
- Workplace discrimination under various laws, including the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990 (as amended).

The various federal agencies that regulate these aspects of worker compensation and protection use different tests to determine which employer should be treated as primary. For example, the Department of Labor employs a multi-faceted *economic reality* test that takes into account (among other factors) the degree of control each party has over how the work is performed; the degree to which each party influences a worker's prospects for profit and loss; and the permanency of the relationship between the parties. The IRS, by contrast, uses the three-factor *common law* test, which examines each party's behavioral control over the worker (e.g., the tools used to perform the work); each party's financial control over the worker (how the worker is paid); and the type of relationship between the parties and the worker (e.g., whether the worker receives benefits).

Risk can arise under the AwC model when workers are misclassified as independent contractors when they should be classified as employees. Over the last several years, the IRS, DOL, and state equivalents of DOL have more strictly enforced this classification. If an AwC pays workers as independent contractors when those workers should properly be classified as employees, both the individual and the agency run the risk of penalties and liability. To determine whether a worker is an employee or an independent contractor, the IRS again uses the common law test. The vast majority of workers providing Personal Care and other Home Health services in self-direction programs should be considered employees, not independent contractors.

According to the National Resource Center for Participant Directed Services (NRCPDS, 2012), "the salient challenge is to implement a model wherein the agency is the primary employer of workers, the participant's right to participant-direct is not eroded, and neither the participant nor agency are vulnerable to significant legal liability beyond each party's control" (p. 22).

Self-Directed Service Model with Individual Budget: According to the final CFC rule, this model "is one in which the individual has both a person-centered service plan and a service budget based on the assessment of functional need" (§441.545(b)). If a state offers the individual budget option under CFC, it must "make available financial management activities to all individuals with a service budget" (§441.545(b)(1)). These activities are carried out by an entity that provides FMS in the form of a *Fiscal/Employer Agent* (F/EA). States can also implement the AwC model and budget authority simultaneously (though the model becomes more complex).

The F/EA model differs from the AwC model in a few key ways. First, under the F/EA model, individuals directly hire their own workers and serves as their sole employers. To support the individual in this role, the F/EA assumes liability under federal law for the withholding, filing, and payment of federal and state payroll and unemployment taxes. F/EAs also comply with responsibilities related to workers' compensation policies. F/EAs verify that payments to workers are authorized; they also confirm that purchases are allowed in the budget and spending plan. F/EAs thus allow individuals to focus on the daily responsibilities of directing their services and supports. (Note that AwCs can also serve as F/EAs. The duties of the AwC then become more complex, and include tracking individual budgets.)

States can offer F/EAs under one of two models. In the first model, the state (or its local delegates) can provide F/EA services. The *Government F/EA* model can be attractive because it allows states to control the provision of these services far more closely. Because this model limits provider choice, however, states can claim only the standard administrative match.

Under the Government F/EA model, States can limit the number of vendors they use and draw administrative match rather than (the typically higher) service match. The *Vendor F/EA* model can be attractive for at least two reasons: because it can help to develop an adequate supply of F/EAs across the state, and because states can claim their Medicaid service match rather than the standard 50 percent administrative match. On the other hand, the Vendor F/EA model has a number of disadvantages. For example, states often find it challenging to monitor the quality of services provided by multiple Vendor F/EAs, which must remain abreast of evolving federal and state law, regulations, and policy. Moreover, state staff must have the resources and expertise to execute appropriate Medicaid provider agreements, and to certify and re-certify vendors. States can limit the number of vendors they use and draw administrative match rather than (the typically higher) service match. But this option requires staff to have the time and expertise to draft detailed requests for proposals, evaluate bids, and execute robust contracts that hold vendors sufficiently accountable.

To date, the prospect of receiving service match for providing Vendor F/EA has not come into play in Colorado, since the state's service match and its administrative match are both 50 percent. Under CFC, the state could receive an additional six percentage points on Vendor F/EA. Importantly, however, the added costs of administering vendor F/EA are likely to outweigh any additional matching funds the state might receive. In the absence of historical data for providing Vendor F/EA, it is difficult to perform a meaningful cost-benefit analysis.

There are two additional models that states can use to provide FMS, though they are used less often than the three we have considered so far. In the *Fiscal Conduit* model, a government or vendor disburses public funds via cash or voucher payments to individuals. In the *Public Authority* or *Workforce Council* (PW/WC) model, an independent or quasi-governmental entity serves as the employer for the purposes of recruitment, training, supervision, and discharge. The program agency serves as the employer for the purposes of payroll and of collective bargaining with the workers' union. The PW/WC may also offer training to consumers and workers, offer emergency back-up services to consumers, and maintain a registry of workers.

States that elect the CFC option can also choose to disburse budgets to individuals as vouchers or as cash. In both cases, the state must ensure that federal and state payroll and employment taxes are withheld, filed, and paid to the appropriate governmental bodies.

6.4 Current Options in Colorado for Delivery of Self-Directed Services

Currently Colorado permits individuals the opportunity to self-direct their services fully or partially in six waivers: the Community Mental Health Supports (CMHS) waiver, the Elderly, Blind, and Disabled (EBD) waiver, the waiver for individuals with Spinal Cord Injuries (SCI), the Children's Extensive Support (CES) waiver, the waiver for individuals with Developmental Disabilities (DD) and the Supporting Living Services (SLS) waiver. Individuals in the CHCBS waiver can choose In-home Support Services (IHSS); individuals in the CMHS waiver can choose Consumer-Directed Attendant Support Services (CDASS); and individuals in the EBD and SCI waivers can choose IHSS or CDASS. Individuals on the CES, DD, and SLS waivers can make use of the Family Caregiver option. (For an introduction to Colorado's waiver system and these self-directed service delivery options, see Section 1.1. For details about individual waivers, see Appendix D.)

Both CDASS and IHSS permit employer authority: Individuals can select, train, manage, and dismiss their attendants. Clients also can delegate these responsibilities to an authorized representative. CDASS also provides for budget authority. CDASS is implemented using the joint-employer, AwC model. The AwC provider is currently Public Partnerships, LLC.

6.5 Training of PAS Participants and Attendants

Many services that could move into CFC currently require training, for self-directing consumers, for service providers, or both. Under the Final Rule for CFC, these training requirements would no longer be permitted under some arrangements for self-direction.

To receive Consumer-Directed Attendant Support Services (CDASS), individuals or their authorized representatives must attend FMS training and develop an Attendant Support Management Plan (ASMP) (10 CCR 2505-10 §8.510.6.A.1 and .2). In-Home Support Services (IHSS) agencies are required to offer peer counseling and an orientation to IHSS (10 CCR 2505-10 §8.552.5.A and .C). Agencies are also required to provide "functional skills training to assist clients and/or authorized representatives in developing skills and resources to maximize their independent living and personal management of health care" (10 CCR 2505-10 §8.552.5.L). Under the Final Rule for CFC, the state must provide training on how to select, manage, and dismiss attendants (§441.520(a)), but it cannot *require* that individuals or their representatives complete such training, because doing so would be inconsistent with the philosophy of self-direction (Preamble, p. 26845).

Currently Colorado also requires that PAS attendants undergo training for a variety of services currently offered under waivers. For example, IHSS has requirements specific to that program (10 CCR 2505-10 §8.552.H). Attendants must also complete training for Personal Care (10 CCR 2505-10 §8.489.42) and for Homemaker (10 CCR 2505-10 §8.490.4.C). Under the agency-based model – both the traditional model and AwC – states would still be able to set minimum training requirements. However, when individuals employ their workers directly or through an F/EA, the state would no longer be able to require minimum levels of training for workers. This is because the right to train belongs to individuals (§441.565(a)).

As CMS notes in the Final Rule, eliminating training requirements for individuals and workers would strengthen a state's commitment to the choice and control that define self-direction. For Colorado, eliminating these requirements would represent a significant policy change. HCPF, advocates, and stakeholders must consider the risks that individuals might face if they choose not to receive ASMP, or if their workers do not receive a minimum level of training, and how those risks might be minimized.

We recommend that the state emphasize the advantages of ASMP so that individuals and families will be more likely to undertake the training voluntarily. We also recommend that the state develop a system to identify individuals and representatives who most need such training and develop a protocol to encourage them, in a targeted fashion, to participate in ASMP. We recommend further that the state and stakeholders together consider the importance of worker training to the health and welfare of individuals. The state may ultimately decide to limit the available FMS for CFC to the AwC co-employer model.

6.6 Department of Labor Rule on Companionship Services

In September 2013, the Department of Labor's Wage and Hour Division released a Final Rule entitled "Application of the Fair Labor Standards Act to Domestic Service." The rule amends the Department's prior rule at 29 CFR 552 to better reflect the intent of Congress to expand the class of workers covered by FLSA. At its most basic, the rule narrows the exemptions employers may claim for workers providing "companionship services." Most workers who provide Personal Attendant Services (PAS) will now be entitled to minimum wage and overtime pay, as well as to pay for time spent traveling from one client to another for the same third-party employer. Most workers employed directly by individuals and families will also be entitled to minimum wage and overtime. The Final Rule goes into effect on January 1, 2015.

To understand how the rule will affect Colorado, it will be helpful to focus on critical changes in the rule and to understand DOL's reasoning for making these changes. To begin, it is worth quoting in full the summary that accompanies the rule:

> In 1974, Congress extended the protections of the Fair Labor Standards Act (FLSA or the Act) to “domestic service” employees, but it exempted from the Act’s minimum wage and overtime provisions domestic service employees who provide “companionship services” to elderly people or people with illnesses, injuries, or disabilities who require assistance in caring for themselves, and it exempted from the Act’s overtime provision domestic service employees who reside in the household in which they provide services. This Final Rule revises the Department’s 1975 regulations implementing these amendments to the Act to better reflect Congressional intent given the changes to the home care industry and workforce since that time. Most significantly, the Department is revising the definition of “companionship services” to clarify and narrow the duties that fall within the term; in addition third party employers, such as home care agencies, will not be able to claim either of the exemptions. The major effect of this Final Rule is that more domestic service workers will be protected by the FLSA’s minimum wage, overtime, and recordkeeping provisions.

According to the new rule, companionship services include "the provision of fellowship and protection for an elderly person or person with an illness, injury, or disability who requires assistance in caring for himself or herself" (§552.6(a)). The category of companionship services "also includes the provision of care if the care is provided attendant to and in conjunction with the provision of fellowship and protection and if does not exceed 20 percent of the total hours worked per person and per workweek." The definition of companionship services also includes a definition of "care." In response to comments on its NPRM, DOL modified its definition so that "care" refers broadly to activities of daily living (ADLs) and instrumental activities of daily living (IADLs), with examples of each (§522.6(b)).

Companionship services do *not* include the performance of "medically related services," a category that is defined by the nature of the services themselves:

> The determination of whether services are medically related is based on whether the services typically require and are performed by trained personnel, such as registered nurses, licensed practical nurses, or certified nursing assistants: the determination is not based on the actual training or occupational title of the individual performing the services. (§552.6(d))

One consequence of restricting the exemption is that agencies will now have to pay workers for their travel time from one job site to another (i.e., one client to another) over the course of a work day (as previously stipulated at 29 CFR 785). Historically, agencies have not compensated their workers for travel time, even when workers must travel considerable distances from one client to another (as in rural areas). The impact of this change could potentially be large, though DOL believes that this change – along with the others described above -- will help to professionalize direct care and make it more attractive as a vocation (a point to which we will return shortly).

Elsewhere DOL notes that third party employers of workers who provide companionship services cannot claim the exemption that FLSA provides, "even if the employee is jointly employed by the individual or member of the family or household using the services." The same does not apply to individuals: "However, the individual or member of the family or household, even if considered a joint employer, is still entitled to assert the exemption, if the employee meets all the requirements of §552.6" (§552.109(a)). In other words, under the AwC joint employment model, agencies cannot claim the companionship exemption even for workers who spend less than 20 percent of their time providing care. By contrast, individuals and their families *can* claim the exemption but *only* if their workers spend less than 20 percent of their time providing care. As a consequence, cases can arise in which agencies are liable for unpaid minimum wage, overtime, and travel time while the individuals who jointly employ those workers are not liable. (Note, however, that this rule changes nothing about individual liability for the withholding, filing, and payment of payroll and unemployment taxes. See Section 5.3 for additional details.)

In the Preamble to the Final Rule, DOL addresses a wide range of concerns raised by comments to its NPRM. Most of these comments concern the impacts of the rule on the supply of direct care workers or the availability of PAS.

Commenters expressed concern that minimum wage and overtime requirements for direct care workers could have an outsized impact on individuals who employ family members as their attendants. Because family members typically provide care for more than 40 hours a week, the rule could make it prohibitively expensive for individuals to employ them. To address this

concern, DOL develops a "bifurcated analysis" that treats family members differently from unrelated workers. A family member can be compensated to the extent that an unrelated worker could hypothetically take his or her place. The number of hours an unrelated worker would spend providing care must ultimately relate in a reasonable fashion to an individual's service plan. Whatever a family member might do otherwise – during what would be "off" hours for another worker – is not compensable. Importantly, this bifurcated analysis means that individuals cannot *underpay* their family members as a way to save money in their self-directed budgets. The number of paid hours must be the same regardless of who provides them. In the words of the Preamble: "the Department does not interpret the law as transforming, and does not intend anything in this Final Rule to transform, all care by a family or household member into compensable work" (p. 126).

Several commenters noted that Medicaid pays only for services and not travel time. In response, DOL notes that although "Medicaid may not provide reimbursement for time that an employee spends traveling between clients, nothing in the Medicaid law prevents a third party employer from paying for that time" (p. 146). The Department makes a similar point about minimum wage and overtime, noting that reimbursement rates could gradually be adjusted to cover increased costs. The impact of requiring minimum wage is unavoidable; the impact of travel and overtime requirements on reimbursement rates is "more uncertain" (p. 287). A great deal depends on the extent to which agencies hire more workers to avoid paying travel and overtime to their current workers, and the relationship between those shifts and the setting of reimbursement rates. (To capture the range of possible outcomes, DOL models the financial consequences of three overtime scenarios.)

The Preamble considers in some detail the implications of the amended rule for state and national progress toward meeting the Supreme Court's 1999 *Olmstead* decision. The Department argues that, on balance, the changes will promote *Olmstead* planning by making direct care a more attractive profession. Among other benefits, a more professional workforce may improve continuity of care in an industry where turnover is high "because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours. Job satisfaction, "the Department notes, "is highly correlated with wages, workload, and working conditions" (p. 307). Improved continuity of care will lead to higher-quality services and better outcomes for individuals.

Notably, DOL tempers its overall optimism about the impact of the rule by pointing out that

> public entities must have in place an individualized process -- available to any person whose service hours would be reduced as a result of the Final Rule -- to examine if the service reduction would place the person at serious risk of institutionalization, and, if so,

> what additional or alternative services would allow the individual to remain in the community. (p. 118)

In other words, states must be proactive as the rule takes effect and its impacts become clearer, making sure to address any potential complications. *Olmstead* concerns do not just arise when institutionalization has already happened or is imminent.

6.7 Minimum Wage, Overtime, and the Companionship Exemption in Colorado

Each year, Colorado's Department of Labor issues a Minimum Wage Order that updates the state's minimum wage for certain types of workers. The latest Minimum Wage Order, Number 29, was issued in 2012; it updated minimum wage requirements for 2013. According to the Order, "health and medical" workers must be paid minimum wage and overtime – a requirement that has been in place for a number of years. The category of "health and medical" is defined as:

> any business or enterprise engaged in providing medical, dental, surgical or other health services including but not limited to medical and dental offices, hospitals, home health care, hospice care, nursing homes, and mental health centers, and includes any employee who is engaged in the performance of work connected with or incidental to such business or enterprise, including office personnel. (Colorado Minimum Wage Order No. 29 §5; 7 CCR §1103-1:5).

Notably, however, Colorado's minimum wage and overtime provisions exempt family members (Colorado Minimum Wage Order No. 29 § 5; 7 CCR §1103-1:5), and the state has not required third-party employers to pay direct care workers for their travel time. As noted in the previous section, starting January 1, 2015, third-party employers will be required to pay travel time.

As of January 1, 2015, third-party employers will not be allowed to claim the companionship exemption for any employees. The impact of this change in Colorado should be minimal, however. The key issue is not the state's definition of companionship but its definition of Personal Care as a Medicaid service (10 CCR 2505-10 §8.489). According to Colorado regulations, Personal Care includes activities such as bathing, shaving, dressing, feeding, and so on. Equally important is what Personal Care workers cannot do:

> Personal care staff shall not perform tasks that are not included under INCLUSIONS for each personal care task listed in Section 8.489.30, or tasks that are not listed. For example, personal care staff shall not provide transportation services and shall not provide financial management services. *Clients, family, or others may choose to make private pay arrangements with the provider agency for services that are not Medicaid benefits, such as companionship*. (8.489.22(B)) [emphasis added]

Put differently, Personal Care staff cannot perform any service that is not listed in regulations. As a consequence, a worker who performs other tasks could be classified as another type of worker altogether, even if he or she is performing Personal Care services some of the time.

Because companionship is not a Medicaid benefit, any agency that claims that a worker is a companion is effectively declaring that the worker primarily provides services that are not Medicaid-reimbursable. This means that Medicaid should not pay for the time they spend as a companion. Instead, Medicaid should only pay for the time they spend providing Personal Care. In practical terms, it would be extremely difficult for Colorado to enforce this distinction. It would be difficult to separate the time a worker spends providing occasional companionship services ("fellowship and protection," in federal language) versus Personal Care without imposing a substantial burden on individuals, workers, and agencies. But because Colorado expressly forbids Personal Care staff from performing any tasks not spelled out in regulation, and companionship is not one of those tasks, agencies cannot currently use the companionship exemption at all. The revised DOL rule does not change this fact.

6.8 Recommendations for Widespread Implementation of Self-Direction Under CFC

Given the complexity of self-directed service delivery options, and the uncertain implications of the new Department of Labor rule for family members employed as care givers, Mission Analytics strongly recommends that HCPF seek technical assistance from experts in the financial, administrative, legal, and regulatory complexities of self-directed service options.

The state can request technical assistance for time-limited TA from the HCBS Technical Assistance Center at www.HCBS-TA.org. For technical assistance on an ongoing basis, we recommend that HCPF contract with a group that specializes in the area of self-directed services, especially financial management services.

7 Summary of Recommendations

In this chapter we summarize the recommendations we have made throughout this report.

Estimating the costs of CFC services that do not fully support activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Some services that could be moved into CFC are in fact bundles of sub-services. Some of these sub-services do not directly support activities of daily living (ADLs) and instrumental activities of living (IADLs) and therefore do not qualify for the enhanced match. An important case in point is Residential Habilitation. If the state ultimately wishes to include Residential Habilitation in CFC, the Colorado Department of Health Care Policy and Financing (HCPF) should perform a time study on this service using methods such as those described by the federal Office of Management and Budget (OMB). This will help determine what share of the service is eligible for the enhanced match.

Estimating the costs of new services. Some of the services that the CFC Council would like to include in CFC are new and therefore lack the historical data needed to project costs.

Containing the costs of CFC. To help contain the costs of adopting CFC, HCPF should consider limiting the provision of Long-Term Home Health (LTHH) (e.g., to 120 days). Estimating these costs will require HCPF to perform additional modeling of the projections we have presented in this report. Limiting LTHH in this way would represent a significant change in policy, and would require HCPF to engage stakeholders to understand the benefits and the risks of this strategy.

We also recommend that Colorado explore with CMS the possibility of providing Health Maintenance as an unbundled activity, just as Personal Care and Homemaker can be offered as individual services under CFC. While this may impose a reporting burden on providers, it may also help Colorado shift additional costs away for LTHH by providing an alternative that may be less expensive and would be eligible for CFC's enhanced federal match.

Eliminating conflicts of interest. CFC requires that states eliminate conflicts of interest in assessment and service provision. These requirements reflect a broader shift by CMS toward eliminating conflicts of interests through the system of Medicaid-funded community long-term services and supports (LTSS). To comply with the conflict of interest standards emerging from CMS, Colorado should separate the activities of eligibility determination, case management, and service provision. In some cases, Community-Centered Boards (CCBs) and Single Entry Points (SEPs) perform all of these functions. Separating these functions will require substantial involvement from stakeholders and will incur additional costs. Colorado should gather the information it needs for these estimates and estimate both the one-time (start-up) costs and the ongoing costs of eliminating conflict of interest wherever possible, and erecting appropriate firewalls in areas where there are few providers (such as in rural and frontier areas).

Monitoring quality. CFC requires states to monitor the quality of services that individuals receive. To establish a robust quality monitoring system for CFC, HCPF should work closely with the CFC Council. This collaboration will help ensure that the state simultaneously builds on work that has already been done and collects information that a range of stakeholders will find informative and empowering. In addition, we recommend that the state use a system that is as uniform as possible across populations and authorities for providing community LTSS (i.e., waiver and State Plan). Adopting a uniform system will reduce the administrative burden on state staff, freeing up scarce dollars to expand services.

Measuring outcomes. CFC also requires states to measure outcomes among individuals served by CFC. To measure outcomes, Colorado should adopt the Money Follows the Person (MFP) Quality of Life (QoL) survey, developed by Mathematica Policy Research. This tool is already being used in the Colorado Choice Transitions (CCT) program. Moreover, it is valid and reliable, and is supported by training materials developed by Mathematica. Whatever tools and systems Colorado chooses to satisfy the data collection requirements of CFC, we strongly recommend that HCPF consult with the CFC Council to determine whether there are additional data elements that might inform the way the state provides community LTSS, both within and beyond CFC.

Evaluating community settings. As noted in the Final Rule for CFC, CMS will shortly publish criteria for determining if the settings in which services are provided are truly community-based. These standards will apply across all authorities that allow states to provide Medicaid-funded community LTSS. Thus, whether or not Colorado ultimately chooses to adopt CFC, the state will need to inventory the settings in which it provides community LTSS to ensure that they comply with the requirements that will appear in the 1915(i) Final Rule. We recommend that the state perform a careful analysis of that rule when it appears. The state may wish to seek outside technical assistance to help it evaluate its current settings and, if necessary, develop a strategic plan for bringing into compliance all of the settings in which the state provides community LTSS.

Securing assistance with self-directed service delivery models. Implementing self-directed service delivery models requires complex and highly technical knowledge. Colorado has successfully implemented both CDASS and IHSS, and can use its experience as a firm foundation for implementing CFC. But because CFC is a new State Plan option, and because self-direction is so central to this option, we recommend that Colorado engage the ongoing services of one or more consultants with a broad range of expertise in this area. Having the support of consultants on key topics will help state staff use their existing expertise to full advantage.

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Appendix A: Rule for 1915(k), Community First Choice

§441.500 Basis and scope.

(a) *Basis*. This subpart implements section 1915(k) of the Act, referred to as the Community First Choice option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

(b) *Scope*. Community First Choice is designed to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

§441.505 Definitions.

As used in this subpart:

Activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

Agency-provider model means a method of providing Community First Choice services and supports under which entities contract for or provide through their own employees, the provision of such services and supports, or act as the employer of record for attendant care providers selected by the individual enrolled in Community First Choice.

Backup systems and supports means electronic devices used to ensure continuity of services and supports. These items may include an array of available technology, personal emergency response systems, and other mobile communication devices. Persons identified by an individual can also be included as backup supports.

Health-related tasks means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

Individual means the eligible individual and, if applicable, the individual's representative.

Individual's representative means a parent, family member, guardian, advocate, or other person authorized by the individual to serve as a representative in connection with the provision of CFC services and supports. This authorization should be in writing, when feasible, or by another method that clearly indicates the individual's free choice. An individual's

representative may not also be a paid caregiver of an individual receiving services and supports under this subpart.

Instrumental activities of daily living (IADLs) means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

Other models means methods other than an agency-provider model or the self-directed model with service budget, for the provision of self-directed services and supports, as approved by CMS.

Self-directed means a consumer controlled method of selecting and providing services and supports that allows the individual maximum control of the home and community–based attendant services and supports, with the individual acting as the employer of record with necessary supports to perform that function, or the individual having a significant and meaningful role in the management of a provider of service when the agency-provider model is utilized. Individuals exercise as much control as desired to select, train, supervise, schedule, determine duties, and dismiss the attendant care provider.

Self-directed model with service budget means methods of providing self-directed services and supports using an individualized service budget. These methods may include the provision of vouchers, direct cash payments, and/or use of a fiscal agent to assist in obtaining services.

§441.510 Eligibility.

To receive Community First Choice services and supports under this section, an individual must meet the following requirements:

(a) Be eligible for medical assistance under the State plan;

(b) As determined annually—

> (1) Be in an eligibility group under the State plan that includes nursing facility services; or
>
> (2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State

plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,

(c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan. The State administering agency may permanently waive the annual recertification requirement for an individual if:

(1) It is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and

(2) The State administering agency, or designee, retains documentation of the reason for waiving the annual recertification requirement.

(d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

§441.515 Statewideness.

States must provide Community First Choice to individuals:

(a) On a statewide basis.

(b) In a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs and without regard to the individual's age, type or nature of disability, severity of disability or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

§441.520 Included services.

(a) If a State elects to provide Community First Choice, the State must provide all of the following services:

(1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.

(2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

(3) Backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart.

(4) Voluntary training on how to select, manage and dismiss attendants.

(b) At the State's option, the State may provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan. Permissible services and supports may include, but are not limited to, the following:

(1) Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a home and community-based setting where the individual resides;

(2) Expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

§441.525 Excluded services.

Community First Choice may not include the following:

(a) Room and board costs for the individual, except for allowable transition services described in § 441.520(b)(1) of this subpart.

(b) Special education and related services provided under the Individuals with Disabilities Education Act that are related to education only, and vocational rehabilitation services provided under the Rehabilitation Act of 1973.

(c) Assistive devices and assistive technology services, other than those defined in §441.520(a)(3) of this subpart, or those that meet the requirements at § 441.520(b)(2) of this subpart.

(d) Medical supplies and medical equipment, other than those that meet the requirements at § 441.520(b)(2) of this subpart.

(e) Home modifications, other than those that meet the requirements at § 441.520(b) of this subpart.

§441.530 [Reserved]

§441.535 Assessment of functional need.

States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:

(a) States may use one or more processes and techniques to obtain information, including telemedicine, or other information technology medium, in lieu of a face-to-face assessment if the following conditions apply:

> (1) The health care professional(s) performing the assessment meet the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
>
> (2) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff; and
>
> (3) The individual is provided the opportunity for an in-person assessment in lieu of one performed via telemedicine.

(b) Assessment information supports the determination that an individual requires Community First Choice and also supports the development of the person-centered service plan and, if applicable, service budget.

(c) The assessment of functional need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual.

(d) Other requirements as determined by the Secretary.

§441.540 Person-centered service plan.

(a) *Person-centered planning process*. The person-centered planning process is driven by the individual. The process—

> (1) Includes people chosen by the individual.

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(3) Is timely and occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual.

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of- interest guidelines for all planning individuals.

(6) Offers choices to the individual regarding the services and supports they receive and from whom.

(7) Includes a method for the individual to request updates to the plan.

(8) Records the alternative home and community-based settings that were considered by the individual.

(b) *The person-centered service plan.* The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual.

(2) Reflect the individual's strengths and preferences.

(3) Reflect clinical and support needs as identified through an assessment of functional need.

(4) Include individually identified goals and desired outcomes.

(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant.

(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans.

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.

(8) Identify the individual and/or entity responsible for monitoring the plan.

(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

(10) Be distributed to the individual and other people involved in the plan. (11) Incorporate the service plan requirements for the self-directed model with service budget at § 441.550, when applicable.

(12) Prevent the provision of unnecessary or inappropriate care.

(13) Other requirements as determined by the Secretary.

(c) *Reviewing the person-centered service plan*. The person-centered service plan must be reviewed, and revised upon reassessment of functional need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

§441.545 Service models.

A State may choose one or more of the following as the service delivery model to provide self-directed home and community-based attendant services and supports:

(a) *Agency-provider model*.

(1) The agency-provider model is a delivery method in which the services and supports are provided by entities, under a contract or provider agreement with the State Medicaid agency or delegated entity to provide services. Under this model, the entity either provides the services directly through their employees or arranges for the provision of services under the direction of the individual receiving services.

(2) Under the agency-provider model for Community First Choice, individuals maintain the ability to have a significant role in the selection and dismissal of the providers of their choice, for the delivery of their specific care, and for the services and supports identified in their person-centered service plan.

(b) *Self-directed model with service budget*. A self-directed model with a service budget is one in which the individual has both a person-centered service plan and a service budget based on the assessment of functional need.

(1) *Financial management entity*. States must make available financial management activities to all individuals with a service budget. The financial management entity performs functions including, but not limited to, the following activities:

(i) Collect and process timesheets of the individual's attendant care providers.

(ii) Process payroll, withholding, filing, and payment of applicable Federal, State, and local employment related taxes and insurance.

(iii) Separately track budget funds and expenditures for each individual.

(iv) Track and report disbursements and balances of each individual's funds. (v) Process and pay invoices for services in the person-centered service plan.

(vi) Provide individual periodic reports of expenditures and the status of the approved service budget to the individual and to the State.

(vii) States may perform the functions of a financial management entity internally or use a vendor organization that has the capabilities to perform the required tasks in accordance with all applicable requirements of the Internal Revenue Service.

(2) *Direct cash*. States may disburse cash prospectively to individuals self-directing their Community First Choice services and supports, and must meet the following requirements:

(i) Ensure compliance with all applicable requirements of the Internal Revenue Service, and State employment and taxation authorities, including but not limited to, retaining required forms and payment of FICA, FUTA and State unemployment taxes.

(ii) Permit individuals using the cash option to choose to use the financial management entity for some or all of the functions described in paragraph (b)(1)(ii) of this section.

(iii) Make available a financial management entity to an individual who has demonstrated, after additional counseling, information, training, or assistance that the individual cannot effectively manage the cash option described in this section.

(iv) The State may require an individual to use a financial management entity, but must provide the individual with the conditions under which this option would be enforced.

(3) *Vouchers*. States have the option to issue vouchers to individuals who self-direct their Community First Choice services and supports as long as the requirements in paragraphs (b)(2)(i) through (iv) of this paragraph are met.

(c) *Other service delivery models*. States have the option of proposing other service delivery models. Such models are defined by the State and approved by CMS.

§441.550 Service plan requirements for self-directed model with service budget.

The person-centered service plan under the self-directed model with service budget conveys authority to the individual to perform, at a minimum, the following tasks:

(a) Recruit and hire or select attendant care providers to provide self-directed Community First Choice services and supports, including specifying attendant care provider qualifications.

(b) Dismiss specific attendant care providers of Community First Choice services and supports.

(c) Supervise attendant care providers in the provision of Community First Choice services and supports

(d) Manage attendant care providers in the provision of Community First Choice services and supports, which includes the following functions:

(1) Determining attendant care provider duties.

(2) Scheduling attendant care providers.

(3) Training attendant care providers in assigned tasks.

(4) Evaluating attendant care providers' performance.

(e) Determining the amount paid for a service, support, or item, in accordance with State and Federal compensation requirements.

(f) Reviewing and approving provider payment requests.

§441.555 Support system.

For each service delivery model available, States must provide, or arrange for the provision of, a support system that meets all of the following conditions:

(a) Appropriately assesses and counsels an individual before enrollment.

(b) Provides appropriate information, counseling, training, and assistance to ensure that an individual is able to manage the services and budgets if applicable.

(1) This information must be communicated to the individual in a manner and language understandable by the individual. To ensure that the information is communicated in an accessible manner, information should be communicated in plain language and needed auxiliary aids and services should be provided.

(2) The support activities must include at least the following:

(i) Person-centered planning and how it is applied.

(ii) Range and scope of individual choices and options.

(iii) Process for changing the person-centered service plan and, if applicable, service budget.

(iv) Grievance process.

(v) Information on the risks and responsibilities of self-direction.

(vi) The ability to freely choose from available home and community-based attendant providers, available service delivery models and if applicable, financial management entities.

(vii) Individual rights, including appeal rights.

(viii) Reassessment and review schedules.

(ix) Defining goals, needs, and preferences of Community First Choice services and supports.

(x) Identifying and accessing services, supports, and resources.

(xi) Development of risk management agreements.

(A) The State must specify in the State Plan amendment any tools or instruments used to mitigate identified risks.

(B) States utilizing criminal or background checks as part of their risk management agreement will bear the costs of such activities.

(xii) Development of a personalized backup plan.

(xiii) Recognizing and reporting critical events.

(xiv) Information about an advocate or advocacy systems available in the State and how an individual can access the advocate or advocacy systems.

(c) Establishes conflict of interest standards for the assessments of functional need and the person centered service plan development process that applies to all individuals and entities, public or private. At a minimum, these standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:

(1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.

(2) Financially responsible for the individual.

(3) Empowered to make financial or health-related decisions on behalf of the individual.

(4) Individuals who would benefit financially from the provision of assessed needs and services.

(5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process.

(d) Ensures the responsibilities for assessment of functional need and person-centered service plan development are identified.

§441.560 Service budget requirements.

(a) For the self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of functional need and person-centered service plan and must include all of the following requirements:

(1) The specific dollar amount an individual may use for Community First Choice services and supports.

(2) The procedures for informing an individual of the amount of the service budget before the person-centered service plan is finalized.

(3) The procedures for how an individual may adjust the budget including the following:

(i) The procedures for an individual to freely adjust amounts allocated to specific services and supports within the approved service budget.

(ii) The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.

(4) The circumstances, if any, that may require a change in the person-centered service plan.

(5) The procedures that govern the determination of transition costs and other permissible services and supports as defined at § 441.520(b).

(6) The procedures for an individual to request a fair hearing under Subpart E of this title if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

(b) The budget methodology set forth by the State to determine an individual's service budget amount must:

(1) Be objective and evidence-based utilizing valid, reliable cost data.

(2) Be applied consistently to individuals.

(3) Be included in the State plan.

(4) Include a calculation of the expected cost of Community First Choice services and supports, if those services and supports are not self-directed.

(5) Have a process in place that describes the following:

(i) Any limits the State places on Community First Choice services and supports, and the basis for the limits.

(ii) Any adjustments that are allowed and the basis for the adjustments.

(c) The State must have procedures in place that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs.

(d) The State must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice services and supports. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided.

(e) The budget may not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but which are not included in the budget.

(f) The State must have a procedure to adjust a budget when a reassessment indicates a change in an individual's medical condition, functional status, or living situation.

§441.565 Provider qualifications.

(a) For all service delivery models:

(1) An individual retains the right to train attendant care providers in the specific areas of attendant care needed by the individual, and to have the attendant care provider perform the needed assistance in a manner that comports with the individual's personal, cultural, and/or religious preferences.

(2) An individual retains the right to establish additional staff qualifications based on the individual's needs and preferences.

(3) Individuals also have the right to access other training provided by or through the State so that their attendant care provider(s) can meet any additional qualifications required or desired by individuals.

(b) For the agency-provider model, the State must define in writing adequate qualifications for providers in the agency model of Community First Choice services and supports.

(c) For the self-directed model with service budget, an individual has the option to permit family members, or any other individuals, to provide Community First Choice services and supports identified in the person-centered service plan, provided they meet the qualifications to provide the services and supports established by the individual, including additional training.

(d) For other models, the applicability of requirements at paragraphs (b) or (c) of this section will be determined based on the description and approval of the model.

§441.570 State assurances.

A State must assure the following requirements are met:

(a) Necessary safeguards have been taken to protect the health and welfare of enrollees in Community First Choice, including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid Program.

(b) For the first full 12 month period in which the State plan amendment is implemented, the State must maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise under the Act, to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

(c) All applicable provisions of the Fair Labor Standards Act of 1938.

(d) All applicable provisions of Federal and State laws regarding the following:

(1) Withholding and payment of Federal and State income and payroll taxes.

(2) The provision of unemployment and workers compensation insurance.

(3) Maintenance of general liability insurance.

(4) Occupational health and safety.

(5) Any other employment or tax related requirements.

§441.575 Development and Implementation Council.

(a) States must establish a Development and Implementation Council, the majority of which is comprised of individuals with disabilities, elderly individuals, and their representatives.

(b) States must consult and collaborate with the Council when developing and implementing a State plan amendment to provide Community First Choice services and supports.

§441.580 Data collection.

A State must provide the following information regarding the provision of home and community-based attendant services and supports under Community First Choice for each Federal fiscal year for which the services and supports are provided:

(a) The number of individuals who are estimated to receive Community First Choice services and supports under this State plan option during the Federal fiscal year.

(b) The number of individuals who received the services and supports during the preceding Federal fiscal year.

(c) The number of individuals served broken down by type of disability, age, gender, education level, and employment status.

(d) The specific number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Act, or the personal care State plan option.

(e) Data regarding how the State provides Community First Choice and other home and community-based services.

(f) The cost of providing Community First Choice and other home and community-based services and supports.

(g) Data regarding how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to receive home and community-based services in lieu of institutional care.

(h) Data regarding the impact of Community First Choice services and supports on the physical and emotional health of individuals.

(i) Other data as determined by the Secretary.

As mandated by §1915(k)(5) of the Social Security Act, the data that CFC states collect will be used to evaluate the CFC program.

§441.585 Quality assurance system.

(a) States must establish and maintain a comprehensive, continuous quality assurance system, described in the State plan amendment, which includes the following:

(1) A quality improvement strategy.

(2) Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.

(3) Measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered service plan, particularly for the health and welfare of individuals receiving such services and supports. These measures must be reported to CMS upon request.

(4) Standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered service plan.

(5) Other requirements as determined by the Secretary.

(b) The State must ensure the quality assurance system will employ methods that maximize individual independence and control, and provides information about the provisions of quality improvement and assurance to each individual receiving such services and supports.

(c) The State must elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community and others to improve the quality of the community-based attendant services and supports benefit.

§441.590 Increased Federal financial participation.

Beginning October 1, 2011, the FMAP applicable to the State will be increased by 6 percentage points, for the provision of Community First Choice services and supports, under an approved State plan amendment.

Appendix B: CMS Questions and Answers about CFC

In the course of evaluating the feasibility of adopting CFC, Colorado has asked CMS questions on a wide range of topics. Those questions – and the answers CMS has provided – appear below.

Questions fell into the categories listed below. Readers can jump quickly to each category by clicking the appropriate link.

Eligibility

Question: Under the eligibility requirements described in §441.510, are Medicaid Buy-In Clients eligible for CFC?

Answer: Yes, Medicaid Buy-In clients have access to CFC services as long as they also have access to nursing facility services.

Question: Colorado further limits financial eligibility for nursing facility services (defined as a stay lasting more than 30 days). To be eligible for admission to a nursing facility, an individual must have an income that does not exceed 300 percent of SSI; a special asset limit also applies. As a consequence, some individuals who are enrolled in Medicaid via the Buy-In Program would not meet financial eligibility for stays lasting more than 30 days. Moreover, similar restrictions will apply to individuals who are newly eligible under the state's Medicaid Expansion (i.e., they will be eligible for nursing home admission only if their incomes do not exceed 300 percent of SSI and they pass the special asset tests). This means that some individuals who are eligible for

the Buy-In program will not be eligible for admission to a nursing facility? Will individuals in this group be able to access CFC services?

Answer: Yes, as long as this group has access to nursing facility services.

Question: It is Colorado's understanding that individuals who are not Medicaid-eligible until they receive a waiver slot (under the 300 percent special income group) cannot access CFC until a waiver slot is available and they are receiving at least one waiver service. Is this correct?

Answer: This is correct.

Maintenance of Effort

Question: Can CMS provide guidance regarding Maintenance of Effort (MOE) requirements under the Patient Protection and Affordable Care Act (PPACA) if some 1915(c) waivers services are moved via 1915(k) into the State Plan?

Answer: MOE guidance confirming PPACA MOE for adults applies until 12/31/13 and for children until 09/30/19 found at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11001.pdf.

If the 1915(c) waiver being amended includes the 217 group [individuals eligible for Medicaid by virtue of being eligible for a waiver], CMS will need more information about proposed changes to scope or limits on the 1915(c) services, and the impact of these changes on all waiver individuals. If the waiver includes the 217 group, CMS will need to ensure that the proposed changes do not cause waiver individuals to lose Medicaid eligibility. The state will need to describe these impacts in a transition plan.

Question: Colorado covers the 217 group in of its waivers, as per 42 CFR 435.217, via the special income group. Can CMS identify whether any groups that qualify for institutional level of care do *not* fall under the 217 category?

Answer: The clients eligible in the 300 percent group are in the 217 category.

Paid Family Caregivers

Question: Are there any specific rules around guardians or relative family caregivers (for example guardian of an adult with intellectual or developmental disabilities) and being able to be paid caregiver (family or non- family member)? Can guardians be paid caregivers under CFC as long as they are not also the “authorized representative” for purposes of Medicaid LTSS?

Answer: Guardians can be paid caregivers provided they do not also serve as the representative for services.

Definition of "Home and Community-Based Setting"

Question: Does CMS have any information on when a final definition of "home and community-based" setting will be published? Providers have raised questions about whether "institutional setting" has been defined in terms of the number of beds, the number of individuals in a facility, or other attributes.

CMS: CMS anticipates a 2013 publication. In the meantime the state should rely on the proposed rule for 1915(i) published in the Federal Register (77 FR 26362).

Question: Can CMS clarify the institutional setting requirements whose decision-making abilities have been impaired due to dementia or other cognitive deficit? Providers have expressed concern that serving such individuals in the community may raise staffing and liability concerns.

Answer: CMS will not be providing any additional guidance until the Final Rule has been published, after which it will assist states.

Question: Can CMS provide additional guidance on the exception/transition process?

Answer: CMS will not be providing additional guidance until the Final Rule has been published, after which it will assist states.

Application and Pre-Print

Question: Is a 1915(k) Community First Choice State Plan Amendment pre-print available for review, to help expedite the application process?

Answer: CMS is currently developing a web based pre-print and anticipated releasing it in the spring of 2013. In the meantime, the state may use the attached file [the application template for 1915(k)] as a guide, but it is not obligated to do so.

Home Health

Question: Can home health agencies be CFC service providers under the Agency Service Delivery model?

Answer: Yes, home health agencies can be CFC service providers under the Agency Service Delivery model as long as they meet the provider qualifications defined by the State.

Question: Because Colorado has not offered personal care in its State Plan, many individuals have instead used the State Plan long-term home health benefit. Can Colorado move some or all of this benefit under CFC, using the traditional agency model?

Answer: No, home health cannot be provided under CFC. The state should refer to the language of the 1915(k) Final Rule for more information on which health-related tasks can be included in CFC. CMS expects that there will be overlap in the activities performed under long-term home health and those performed under CFC, and that many individuals will receive both types of services.

The Nurse Practice Act

Question: Under the In-Home Support Services (IHSS) and Consumer-Directed Attendant Support Services (CDASS) available under several waivers, Colorado waives portions of its Nurse Practice Act (CRS 25.5-6-1102(7) and 25.5-6-1203(3)). This expands the set of individuals who can carry out health-related tasks. Can Colorado also waive portions of its Nurse Practice Act under CFC?

Answer: CMS generally defers to the states regarding the sections of its Nurse Practice Act it wishes to waive.

Supported Employment

Question: According to §441.520(b)(2), CFC can cover "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human independence, to the extent that expenditures would otherwise be made for the human assistance." Does this section enable the state to include services like supported employment or respite care under CFC?

Answer: Upon review of the state's 1915(c) supported employment activities, it does not appear that a similarly defined service would be allowable under the CFC benefit. 42 CFR 441.500(b) specifies that the scope of CFC is to make available home and community-based attendant services and supports to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks through hands on assistance, supervision, or cuing. 42 CFR 441.520 describes the services that are available under the CFC benefit and all of the activities described must be provided within the scope of the CFC benefit, including activities that increase an individual's independence or substitutes for human independence, to the extent that expenditures would otherwise be made for the human assistance.

"Supported Employment" is not an activity included in the CFC benefit, however, there are activities available through the CFC benefit that may be used to in conjunction with a State's supported employment program. For example, providing assistance with ADLs at an individual's place of employment is allowable under CFC, because this falls within the scope of the CFC benefit. However, on-the-job skills training could not be covered under the CFC benefit, as this

type of activity is outside of the scope of the CFC benefit. Furthermore, the state must provide an assurance that it will adhere to the exclusion of vocational rehabilitation services provided under the Rehabilitation Act of 1973, found at section 1915(k)(1)(C) of the Social Security Act and 42 CFR 441.525(b).

Massage, Acupuncture, and Chiropractic Services

Question: Can CFC include massage, acupuncture, and chiropractic services, as described in Colorado's waiver for individuals with Spinal Cord Injury?

Answer: Massage, acupuncture, and chiropractic services do not fit within the scope of the CFC service benefit.

Reporting Requirements

Question: Does CMS require that Colorado track level of care in MMIS or CBMS (the state's eligibility and enrollment system)? Does CMS have requirements about where (in which system) the reports originate?

Answer: At this time CMS has not specified which system should be used to provide the required information. For now, CMS wants assurances from Colorado that it has a process to capture the information.

Claiming Enhanced Match in an Integrated Delivery System

Question: Does CMS have a way to claim services provided through an organized integrated delivery system for enhanced match? A time study has been presented as one option. Are there others that would be approvable? Can CMS provide any examples from other states where this has been done?

Answering: CMS recommends that the state consult OMB Circular A-87.

Appendix C: CFC Focus Group Summaries

As part of our work helping Colorado assess the feasibility of the Community First Choice (CFC) State Plan option, we conducted stakeholder focus groups and interviews. These focus groups are part of a larger effort by the state to move toward person-centered services and supports that help individuals exercise choice and control and live the lives they want to live. The goal of these interviews was to gather information on Medicaid-funded home and community-based attendant care services and supports. The interview protocol invited individuals to offer feedback on what is working well, what is not working well, and the challenges or barriers they face in providing or receiving daily self-care activities.

Focus Group Outreach and Attendance

To maximize participation in the focus groups, HCPF recruited individuals for the focus groups using the following outreach strategies:

- HCPF announced the focus groups via email to over 1,000 long-term services and supports (LTSS) stakeholders.
- HCPF also emailed the CFC Council Stakeholder list and encouraged Council members to share information about the focus groups with their communities.
- The Colorado Cross-Disability Coalition (CCDC) emailed notices to all of their members and also posted a notification on their website.
- The ARC of Colorado emailed notices to all of their chapters statewide.
- All HCPF staff were informed by email of the focus groups and were asked to share the announcement with stakeholders.
- All Single Entry Point (SEP) agencies in the state were informed by email.
- Alliance, the statewide association of Community Centered Boards (CCBs) and Service Provider Organizations (SPOs), informed all of their members statewide.
- Focus groups were publicized at CFC Council meetings and at all meetings of the individual-Directed Programs Policy Collaborative (formerly CDASS Advisory Committee).
- To encourage participation and to compensate individuals for their time, HCPF provided travel reimbursement, food and refreshments, and a $20 gift card.

The initial intent was to interview individuals in three focus groups: one composed of service recipients in the Metro Denver area; one composed of attendants in the Metro Denver area; and one composed of service recipients in rural areas, to be held via teleconference. However, due to the scheduling constraints of individuals and attendants in rural areas, Mission instead conducted one-on-one phone interviews with these individuals.

Despite our efforts to make participation as easy as possible, attendance in the focus groups was not as robust as we had hoped. Twelve (12) individuals were scheduled to participate in the first in-person focus group for service recipients, but only four attended. Two individuals came with their parents; the other individuals were parents of individuals who were not present. Three individuals were scheduled to participate in the focus group for attendants, but only one attendant came. Mission later conducted phone interviews with three individuals who receive services, along with one attendant. Because participation in the focus groups was low, Mission also emailed the interview questions to every individual who had initially agreed to participate, with an offer to collect their feedback by email or phone; however, this outreach did not result in any additional information.

Findings

All focus group and interview individuals were asked a similar set of questions. Mission staff informed individuals of the purpose of the interviews, their general structure, and the maintenance of confidentiality. We also asked each group or individual respondent for permission to make a recording. A list of questions asked of each group can be found below. In general, we allowed respondents some flexibility to guide the conversation so not all interview questions were asked of all respondents.

A review of responses revealed the following themes:

Respondents who felt they were receiving the correct services reported overall satisfaction with those services. Respondents mentioned Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Consumer-Directed Supports and Services (CDASS) as services that worked well. One stakeholder reported that EPSDT provides a level of comprehensiveness and consistency that meets her family's needs.

Recipients of CDASS and In-Home Support Services (IHSS) often reported feeling that services were person-centered, at least in some respects. Stakeholders felt they had control over selecting and retaining attendants who provided services. One IHSS recipient reported having to replace his IHSS attendants because of general dissatisfaction. He is satisfied with his current attendants. Individuals and families would like to self-direct many more services than the system currently permits. For example, one recipient of CDASS services interviews and hires her attendants, but she has little control over how the agency she works with recruits and screens applicants. She reported that this results in a small pool of qualified applicants, and she cannot afford to conduct her own recruitment.

Supported employment can be a very positive service. One family in particular reported success with supported employment and overall satisfaction with vocational services.

Even individuals who are satisfied with their current services often do not think they receive sufficient hours to meet all of their daily living needs. For example, one individual reported that the amount of time allotted for his attendant to assist with grocery shopping is not enough time to bring him to the store. To save attendant resources, he does not accompany the attendant to the store, even though that would be his preference.

The system is complex and individuals and families often do not know which services are available to them. At the most basic level, individuals may not even know whether they qualify for services. The process of determining eligibility may be exacerbated by lack of transparency and the sense of stigma associated with receiving Medicaid.

Individuals and families may know what they need, but not how to get it, or how to navigate the system. Focus group respondents often reported that they were more successful at getting services when they became advocates. Several individuals had spent years developing expertise navigating the system and advocating for benefits on behalf of themselves or their family members. Many commented that it would be very hard to navigate the system for someone who either did not understand the intricacies of the system, or did not feel comfortable advocating on their own behalf. One stakeholder noted that some people might be afraid to attend focus groups or meetings because doing so might jeopardize their services.

The seemingly rigid nature of the system can create problems. An individual may be on a waiver that actually provides more services than he or she needs, but there is no better alternative (usually because that waiver is the only one that provides a service that the individual finds especially vital). Or an individual may need a service that is available on a waiver with a waitlist. In some cases, the service may not be offered in the State Plan or in any waiver.

Waitlists can create tremendous hardships. Individuals can remain on waitlists for years – even when they (or their family members) know enough about the system to place them on the waitlist long before they will need the services of a given waiver.

The transition from youth to adulthood is an especially difficult time for families because individuals cannot transition seamlessly from one waiver to another. One stakeholder reported that she is currently satisfied with many services that her family receives, but when her children turn 21 they will not be able to remain on their current waiver. Yet, despite being on a waitlist for several years, they will not be eligible to transition to the new waiver until slots open up.

For families with children who receive services, the reliance on "natural supports" may become a problem, especially as parent caregivers age. For many parents interviewed, the reliance on natural supports raises difficult questions about what will happen when they experience an illness or become unable to care for their family members.

It is difficult to sustain a career as an attendant due to low pay, minimal support, and less than full time employment. Stakeholders repeatedly told us that pay rates for attendants are very low; attendants often receive insufficient training; and the training that is required may not be reimbursed by agencies. Family members who are working as attendants often find the complexities of working as an independent contractor to be daunting.

Stakeholders frequently reported transportation issues that varied greatly from region to region. Some transportations services require 24-hour advance scheduling notice, even for standing weekly appointments (i.e., rides cannot be scheduled on a standing basis). More rural areas may have very limited public transportation and few companies that provide private transportation (e.g. taxis). Even in Metro Denver, transportation is limited in some key aspects. Access-A-Ride can be quite expensive for those with limited resources. The number of vans available through Access-A-Cab is very limited.

Rural areas pose unique challenges. Most of the rural areas of the state lack public transportation, population centers are scattered and often many miles apart, and services are generally scarcer. Attendants must travel many miles and are not properly reimbursed for mileage and travel times.

Focus Group Protocol: Individuals/Families

Welcome. We have come here today to discuss Medicaid home and community-based attendant care services and supports. These services support activities that you or your family members do every day, like eating, toileting, and transferring. These services also help you or your family member to live independently by helping to plan meals, shop, and perform chores around the house.

We want to know what is working well with these supports, what is not working well, and what challenges you or your family member face in receiving daily self-care activities. This focus group is part of a larger effort by the state of Colorado to move toward person-centered services and supports that help individuals exercise choice and control and live the lives they want to live.

My name is Kira Gunther and I will be moderating the focus group. Let's go around the room and introduce ourselves, and it would be helpful if you could each write down your first name on the tent cards. [Introductions around the room]

I will be asking you a series of general questions, and Ed and I will be taking notes. All of your comments will remain confidential. We may use quotes but we will never use your name with a specific comment or idea. Feel free to speak up at any time, but we should all be mindful to take turns and let everyone have a chance to voice his or her opinions.

Feel free to address one another, not just the moderator.

We would like you to think about an ideal system to suit your needs. You may have examples of services that do or do not work well for your particular needs, and you will have an opportunity to cite some examples, if you like. We welcome both positive and negative comments.

The session will last from 60-90 minutes. If you need to use a rest room, they are located [explain location]. Please help yourself to food or snacks during the session.

At the end of the session, you will be each given a gift card to compensate you for your time.

Any questions before we begin?

1. First, we would like to learn a little bit more about the types of services you are receiving. You may not know the answer to this question. For those of you who do know, which types of services do you currently receive? Are you on a particular waiver? Do you receive CDASS, IHSS, or other specific types of services?
2. What self-care activities are *not* available to you that you need to live the life you want?
3. What is the most useful self-care service that you currently receive? What makes that service so useful?
4. What self-care services, if any, are *not* useful or not provided in a useful way? What makes them less useful than they could be?
5. What services do you receive to help you with daily tasks even when an attendant is not physically present, such as calls to remind you to take your medication?
6. What barriers have you experienced getting support to help you with activities of daily living such as bathing and dressing?
7. If you needed new or different services to help with daily self-care activities, how would you find out what services are available? How would you find out if you qualify for those services? How would you find out how to access them?
8. What services are available to you to help you find a job? What services are available to you to help you keep a job?
9. What transportation services do you currently receive? (For what activities?) What, if any, additional transportation help do you need to access services? (For what activities?)
10. If you could change the services you receive in any way, what would you change?
11. Do you feel you have choice and control over the services you receive – *when* you receive them, *where* you receive them, and *who* provides them? If you don't feel you have choice and control, what problems or limitations have you encountered?
12. How do you think your needs will change over time? What services do you think you'll need in the future to live the life you would like to lead?

Focus Group Protocol: Attendants

Welcome. We have come here today to discuss Medicaid home and community-based attendant care services and supports. These services support activities that consumers do every day, like eating, toileting, and transferring. These services also help consumers to live independently by helping to plan meals, shop, and perform chores around the house.

We want to know what is working well with these supports, what is not working well, and what challenges you face in providing supports for daily self-care activities. This focus group is part of a larger effort by the state of Colorado to move toward person-centered services and supports that help individuals exercise choice and control and live the lives they want to live.

My name is Kira Gunther and I will be moderating the focus group. Let's go around the room and introduce ourselves, and it would be helpful if you could each write down your first name on the tent cards. [Introductions around the room]

I will be asking you a series of general questions, and Ed and I will be taking notes. All of your comments will remain confidential. We may use quotes but we will never use your name with a specific comment or idea. Feel free to speak up at any time, but we should all be mindful to take turns and let everyone have a chance to voice his or her opinions.

Feel free to address one another, not just the moderator.

We would like you to think about an ideal system to suit your needs. You may have examples of services that do or do not work well for your particular needs, and you will have an opportunity to cite some examples, if you like. We welcome both positive and negative comments.

The session will last from 60-90 minutes. If you need to use a rest room, they are located [explain location]. Please help yourself to food or snacks during the session.

At the end of the session, you will be each given a gift card to compensate you for your time.

Any questions before we begin?

1. First, we would like to learn a little bit more about the types of services you are providing. What types of services do you currently provide?
2. Are these services sufficient to meet the needs of the individuals you support? If not, what services are not available to the people that you support that they may need to live the life they want?
3. What are the most useful self-care services that you currently provide? What makes these services useful?
4. What self-care services, if any, are not useful or not provided in a useful way?
5. What services do you provide, like medication reminder calls, when you are not physically present?
6. What barriers have you experienced in providing services?
7. How would you characterize your relationship with the individuals you support?
8. What types of support do you receive from your employer to provide services effectively?
9. What kind of training (if any) is offered to the consumers you support to help them exercise choice and control over the services they receive? If they don't currently receive any training, what kind of training do you think should be provided to them?
10. Do you feel you the services your agency provides are person-centered? If not, what prevents those services from being person-centered?
11. What changes would you make to the system to make it more effective?
12. In your mind, what would an ideal system look of services and supports look like? What kind of system would help consumers live the lives they want to live? What would your role look like in this ideal system?

Appendix D: Waivers in Colorado

Colorado currently maintains 12 waivers: seven for adults and five for children.

The waiver for **Persons with Brain Injury (BI)** provides services to individuals with a brain injury, aged 16 to 64. The waiver provides adult day services; specialized medical equipment and supplies; behavioral management; day treatment; home modifications; mental health counseling; non-medical transportation; personal care; respite care; substance abuse counseling; supported living; transitional living; and personalized emergency response system (PERS). BI requires hospital or nursing home level of care. For waiver year 1, it has a cap of 313 individuals and increases slightly each year thereafter. There is no wait list, but there is currently insufficient capacity to provide supported living to all individuals who want it. Individuals who cannot access supported living can still access all other services in the waiver.

The **Community Mental Health Supports (CMHS)** waiver provides services to individuals aged 18 and older who have been diagnosed with a major mental illness. The waiver provides adult day services; alternative care facilities; CDASS; PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. CMHS requires nursing home level of care. It has a cap of 3,104 individuals for waiver year 2, which increases slightly each year thereafter. There is no wait list.

The waiver for **Persons Living with AIDS (PLWA)** provides services to individuals of all ages with a diagnosis of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). The waiver provides adult day services; PERS; homemaker services; non-medical transportation; and personal care. PLWA requires nursing home or hospital level of care. It has a cap of 200 individuals. There is no wait list.

The waiver for **Persons who are Elderly, Blind, and Disabled (EBD)** provides services to individuals aged 65 and older with a functional impairment, or to adults aged 18 through 64 who are blind or physically disabled. The waiver provides adult day services; alternative care facilities; community transition services; CDASS; PERS; home modifications; homemaker services; IHSS: non-medical transportation; personal care; and respite care. EBD requires nursing home level of care. It has a cap of 23,506 individuals for waiver year 1, which increases slightly each year thereafter. There is no wait list.

The waiver for **Persons with Spinal Cord Injury (SCI)** provides eligibility to individuals aged 18 and older who have a spinal cord injury. The SCI waiver is a pilot program that runs through June 2015. It provides adult day services; alternative therapies (acupuncture, massage and chiropractic care); CDASS; IHSS;PERS; home modifications; homemaker services; non-medical transportation; personal care; and respite care. The waiver has an independent evaluation to

measure the cost-effectiveness and improved quality of life for eligible participants who are enrolled on the waiver and utilize the alternative therapy services. The waiver requires nursing home level of care. It has a cap of 67 individuals. There is no wait list.

The **Supported Living Services (SLS)** waiver provides services that help individuals aged 18 and older with developmental disabilities to live in their own home, family home, or rental unit that qualifies as an SLS setting. The waiver provides services as an alternative to institutional placement for individuals with developmental disabilities, but it does not provide 24-hour supervision. To be eligible for SLS, individuals must either live independently with supports, or already receive services from other sources, such as family members. The waiver provides assistive technology; behavioral services; day habilitation services; dental services; supported employment; prevocational services; home modifications; homemaker services; mentorship; personal care; PERS; professional services (e.g., hippotherapy); respite services; specialized medical equipment and supplies; transportation; vehicle modifications; and vision services. SLS requires a level of care that meets that of intermediate care facility for individuals with intellectual disabilities (ICF/IID). The waiver has a cap of 3,241 individuals. There is a wait list.

The **Comprehensive Waiver for Persons with Developmental Disabilities (DD)** provides services to individuals aged 18 and older who have a developmental disability. The waiver provides behavioral services; day habilitation; prevocational services; dental services; residential services (24-hour individual or group); transportation; specialized medical equipment and supplies; supported employment; and vision services. The DD waiver requires ICF/IID level of care. It has a cap of 4,525 individuals. There is a wait list.

The **Children's HCBS (CHCBS)** waiver provides services to medically fragile children aged birth through 17 who have a disability. The CHCBS waiver does not require a child to have a developmental disability or delay, but it does serve children with developmental disabilities or delays who have concurrent medical conditions. The waiver provides case management and IHSS. CHCBS requires hospital or nursing home level of care. It has a cap of 1,308 children. There is a wait list.

The **Children with Autism (CWA)** waiver provides services to children aged birth through five who have a diagnosis of autism. The waiver provides just one service: behavioral therapy. CWA requires ICF/IID level of care. It has a cap of 75 children. There is a wait list; children who are most in need due to the severity of their disability are prioritized for enrollment.

The **Children's Extensive Support (CES)** waiver provides services to children aged birth through 17 who have a developmental delay or disability. To be eligible for CES, children must also have intensive behavioral or medical needs. The waiver provides adapted therapeutic recreation; assistive technology; behavioral services; community connections (to allow children to

participate in community-based activities); home accessibility adaptations; homemaker services; parent education; personal care; professional services (e.g., hippotherapy); respite; specialized medical equipment and supplies; vehicle modification; and vision services. CES requires ICF/IID level of care. Funding was recently allocated to eliminate the waitlist, a process that should be complete by the end of fiscal year 2013-2014. At that time, the cap will be 659.

The **Children's Habilitation Residential Program (CHRP)** waiver provides services to children and youth aged birth through 20 who are in foster care and who have a developmental disability and extraordinary needs. CHRP provides cognitive services; communication services; community connections; emergency services; personal assistance services; self-advocacy; supervision; and travel. CHRP requires ICF/IID level of care. It has a cap of 200 children. There is no wait list.

The waiver for **Children with a Life-Limiting Illness (CLLI)** provides services for children aged birth through 18 who have a life-limiting illness. To be eligible for the waiver, children must need hospital level of care and have a life-limiting illness where death is probable before adulthood. CLLI provides counseling/bereavement services; expressive therapy; palliative/supportive care; and respite care. It has a cap of 200 children. There is a wait list.

Appendix E: Illustrated Overview of CFC Cost Analysis Tool

The CFC cost model developed by Mission Analytics Group (Mission) allows users to estimate the cost of moving selected services from Colorado's waivers into the State Plan. Using data supplied by the Colorado Department of Health Care Policy and Financing (HCPF), Mission has designed an interactive Excel workbook that allows users to specify:

1. The services that move from waivers to the State Plan;
2. The cost of waitlist clients relative to waiver clients who currently receive CFC services;
3. The cost of individuals who do not have access to a service (because they are on, or waiting for, a waiver that does not offer the service, or because they are not receiving any waiver services) relative to the costs of individuals who currently receive that service – individuals we will call "new service-eligible clients";
4. The share of new service-eligible clients who will use CFC services, both across services and at a service-specific level;
5. The share of individuals currently using Long-Term Home Health (LTHH) who will use CFC services;
6. The share of individuals currently using LTHH who will continue to use LTHH; and
7. The number of clients who are new to long-term services and supports (LTSS) – that is, non-waiver, non-waitlist, non-LTHH clients.

The model outputs the difference in cost to the Colorado General Fund of adopting CFC. In this document, we describe how users interact with the model to derive these cost estimates.

The model is designed to be flexible: Users can develop a range of scenarios about the service array for CFC and the costs of CFC services and quickly see the impact of those scenarios on overall costs. Because the purpose of this appendix is to describe how users interact with the model – rather than to explain how different scenarios affect cost – we have opted to present just one hypothetical scenario. Note that the specific choices we describe are for illustration purposes only; they do not represent decisions by the state of Colorado or by the Community First Choice Council.

We implemented the cost model in an Excel workbook that consists of several worksheets. Most of these worksheets contain data obtained from HCPF and are ordinarily hidden from the user. Unless users need to load updated data into the workbook, they generally interact only with the Services worksheet. For that reason, we will describe the Services worksheet in some detail. To help explain how the figures in the Services worksheet are computed, we will also briefly describe the other worksheets in the workbook.

Most readers can get a good sense of how users interact with the Excel model by reading about the Services worksheet and consulting Exhibits E.1 and E.2. Readers wishing to know more about how the model is implemented in Excel may find it useful to read about the other worksheets, but it is not necessary to do so. Because the other figures are less essential, we present them at the end of this appendix; this will avoid breaking up the text and make this appendix easier to read.

The Services worksheet is wide and difficult to represent clearly on a single page. We have therefore split an image of the worksheet into two figures (Exhibits E.1 and E.2). The portion of the Services worksheet that allows users to make choices appears in Exhibit E.1; Exhibit E.2 provides an “at-a-glance” look at projected costs.

In Exhibit E.1, candidate CFC services appear on the right. Each service can be turned "on" by selecting "Yes" from a drop-down menu in the column labeled "CFC." In this illustration, the following services have been set to "Yes":

- Consumer-Directed Attendant Services and Supports (CDASS);
- Homemaker;
- In-Home Support Services (IHSS);
- Personal Care;
- Personal Emergency Response System (PERS); and
- Residential Habilitation.

Note that although LTHH appears in the list of CFC services, it is not in fact eligible to become a CFC service. Instead, it appears in the list so that we can establish the extent to which clients substitute CFC services for LTHH.

To help explain the choices available to users, we have labeled selected highlights of the worksheet with the numbers 1 through 5.

Exhibit E.1: Part 1 of the Services Worksheet: Services, Costs, Take-up, and Number of Clients

Cost of Wait List Clients Relative to Waiver Clients	Mean
Cost of Other Client Relative to Costs Across Waivers	Max
Default Statewide Take Up	0%
Expected # of Non-waiver, Non-waitlist, Non-LTHH Clients	1500

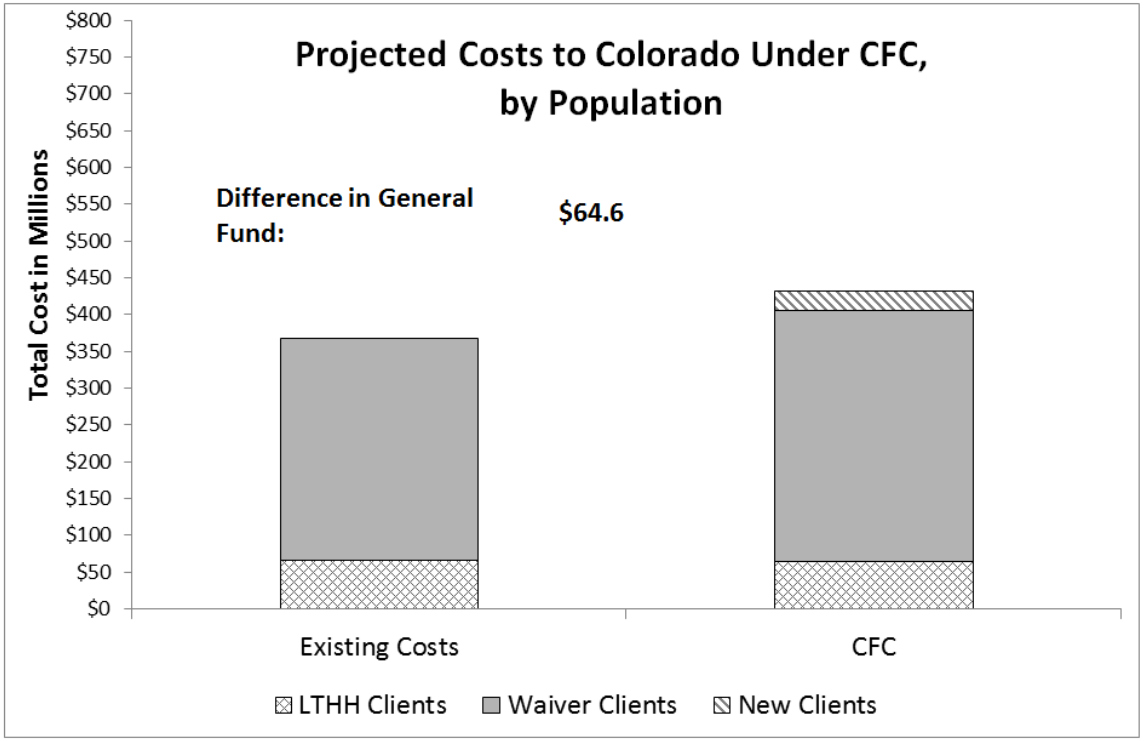
Summary by Service

Summary by Service by Population

Total Costs

Service	CFC	Default % Non-Waiver/Non-Waitlist Take Up	% Non-Waiver/Non-Waitlist Take-Up (Overrides Default)	% LTHH Population Using Service	Share of Service Eligible for Enhanced Match (Default = 100%)
Adult Day Services	No	0%			
Alternative Care Facility (ACF)	No	0%			
Behavioral Management	No	1%	1%		
Behavioral Therapies	No	20%	20%		
Case Management	No	0%			
CHRP Habilitation	No	0%			
CHRP Professional Services	No	0%			
Client/Family/Caregiver Counseling	No	0%			
Community Connection Services	No	0%			
Community Transition Service (CTS)	No	0%			
Consumer Directed Attendant Support Services (CDASS)	Yes	15%	15%	2%	
Day Habilitation	No	0%			
Day Treatment	No	0%			
Dental Services	No	0%			
Expressive Therapy	No	0%			
Home Modification	No	0%			
Homemaker	Yes	50%	50%	5%	
In Home Support Services	Yes	10%	10%	1%	
Independent Living Skills Training (ILST)	No	10%	10%		
Long-Term Home Health	Yes	**0%**		**90%**	**0%**
Mental Health Counseling	No	5%	5%		
Non-Medical Transportation	No	50%	50%		
Palliative/Supportive Care Services	No	0%			
Personal Care	Yes	50%	50%	5%	
Personal Emergency Response Systems	Yes	45%	45%		
Professional Services	No	0%			
Residential Habilitation	No	0%			
Respite	No	40%	40%	2%	
Specialized Medical Equipment/Supplies	No	0%			
Substance Abuse Counseling - SLP	No	0%			
Supported Employment	No	0%			
Vision Services	No	0%			

Exhibit E.2: Part 2 of the Services Worksheet: Costs to the Colorado General Fund of Adopting CFC



Cost of Wait List Clients Relative to Waiver Clients	Mean
Cost of Other Client Relative to Costs Across Waivers	Max
Default Statewide Take Up	0%
Expected # of Non-waiver, Non-waitlist, Non-LTHH Clients	1500

Summary by Service

Summary by Service by Population

Total Costs

Table 7.1 - Current Costs and Costs Under CFC

Row Number	Fund	Population	Existing Costs	CFC	Difference
A	State General Fund	LTHH Clients	$ 65,243,143	$ 63,327,803	$ (1,915,340)
B	State General Fund	Waiver Clients	$ 302,235,792	$ 341,746,981	$ 39,511,189
C	State General Fund	New Clients	$ -	$ 26,976,599	$ 26,976,599
D	Federal	LTHH Clients	$ 65,243,143	$ 64,584,796	$ (658,347)
E	Federal	Waiver Clients	$ 302,235,792	$ 378,591,050	$ 76,355,258
F	Federal	New Clients	$ -	$ 34,333,853	$ 34,333,853

Highlight 1 shows the choices we have made about costs, take-up, and the number of completely new clients. The model requires us to indicate the expected cost of waitlist clients who will be using CFC services. These costs are set relative to the costs of existing waiver clients for those same services. Next to the cell labeled "Cost of Waitlist Clients Relative to Waiver Clients," we can choose the *mean* (or average), the *median* (or mid-point), or the *25th percentile* (meaning that the cost of waitlist clients is expected to be fairly low compared to the cost of waiver clients). In this case, we have chosen the mean.

The model requires us to specify the anticipated cost of new service-eligible clients relative to the costs of those same services across all waivers that provide it. Next to the cell labeled "Cost of New Service-Eligible Clients Relative to Costs Across Waivers," we can choose the *mean*, the *minimum* (the least costly waiver), or the *maximum* (the most costly waiver). In this case, we have chosen the maximum.

The model assumes that waitlist clients will use CFC services at the same rate that waiver clients use them. For example, to establish the percentage (or share) of waitlist clients on the Elderly, Blind, and Disabled (EBD) waiver who will use CDASS, the model uses the share of EBD waiver clients who use CDASS. However, the model makes no assumptions about the share of clients who will use services to which they previously had no access – either because they were not on a waiver (or on a waitlist for a waiver) that offered that service, or because they are completely new clients. The model thus requires us to specify this share next to the cell labeled "Take-Up Among New Service-Eligible Clients." In this scenario, we have set the default to zero percent, because we have used service-specific overrides derived from historical data.

Finally, the model requires us to indicate how many new clients will be eligible for CFC services. This number represents the total population of individuals who meet institutional level of care and are not on a waiver, on a waitlist, or currently receiving LTHH. In this example, we have set that number to 1500.

All of these settings can be adjusted as new information is collected about costs and about the number of individuals likely to be eligible for CFC services.

Highlight 2 shows that we have set CDASS to "Yes," meaning that it will move into the State Plan. We have also set the expected take-up to 15 percent, which overrides the default take-up for new service-eligible clients of zero percent (see the column labeled "Override % Take-Up Among New Service-Eligible Clients"). Finally, we have specified that 2 percent of current LTHH clients will use CDASS (see the column labeled "% LTHH Population Using Service").

Note that the model permits current users of LTHH to use more than one CFC service. Thus, entering "2%" for CDASS means that CDASS will be used by 2 percent of LTHH clients. But those same clients may use other services as well.

Highlight 3 shows the settings for LTHH. As noted earlier, if there is reason to believe that some LTHH clients will use CFC services instead of LTHH, the service must be set to "Yes." Note, however, that the statewide take-up for LTHH is always set to zero percent. This means that non-waiver, non-waitlist clients who meet institutional level of care will not add to the number of clients currently receiving LTHH. There is a simple reason for this constraint: Everyone who meets institutional level of care is already eligible for LTHH; if they wish to receive LTHH, the service is already available to them.

Highlight 3 also shows the share of LTHH clients who will use LTHH once CFC is adopted (see the column labeled "% LTHH Population Using Service"). In this case, we have set the value to 90 percent. This means that 90 percent of current LTHH clients will continue to receive LTHH, in addition to whatever CFC services they qualify for and wish to receive. In this example, we expect 10 percent to drop LTHH and use one or more CFC services to replace LTHH altogether.

Exhibit E.2 shows the second half of the Services worksheet. It provides the best “at-a-glance” look at projected costs. The bar chart shows the projected difference in costs under CFC. The stacked bar on the left represents current costs for waiver clients and LTHH clients without CFC. The stacked bar on the right represents the costs for waiver clients, LTHH clients, and new clients once CFC has been added to the State Plan. The crosshatched area of each bar represents the cost of LTHH clients; the solid gray area represents the cost of waiver clients; and the striped area represents the costs of new clients. Note that these are the aggregate costs for groups of individuals, not for the services labeled "LTHH" or "waiver." Even though some members of the LTHH population will stop using LTHH and use CFC instead, the total cost of the current LTHH population can increase because a) clients may use multiple CFC services, and because b) some members of the current LTHH population may continue to receive LTHH *and* receive CFC services.

The figure above the bar chart summarizes the total cost. Given the settings we have provided to the model in this example, adopting CFC will cost the Colorado General Fund $64.6 million.

The table below the graph shows the same information numerically, with rows for fund type (federal and General Fund) and columns for populations (LTHH, waiver, and new), existing costs, costs under CFC, and the difference between the two. We calculate changes to the General Fund by subtracting the values in the column labeled "Existing Costs" from the values in the column labeled "CFC." Positive values indicate a cost increase; negative values (in parentheses) indicate a cost savings.

Under this scenario, Colorado would:

- Spend roughly $2 million less on its current LTHH clients;

- Spend roughly $39.5 million more on its existing waiver clients (largely because waiver clients who currently have to access to few or no CFC services will now have access to those services); and
- Spend roughly $30 million more to serve new clients (both waitlist clients and entirely new clients).

Note that federal costs go up for all populations.

As noted earlier, the remaining worksheets in the cost model workbook ordinarily remain hidden. In the remainder of this appendix, we will describe those worksheets to clarify how the total costs presented on the Services worksheet are computed. Note that in the worksheets we describe next, cells colored in green contain either FTEs that come directly from HCPF or costs that are calculated from those FTEs. All other cells contain FTEs and costs that are computed based on the decisions made on the Services worksheet (see Exhibit E.1).

Exhibit E.3 presents a screenshot of the Expanded Summary worksheet. It presents the current cost figures and compares them to the costs under CFC as defined by the user's assumptions. It presents the costs under CFC in detail, breaking them out by population – clients currently receiving LTHH, current waiver clients, and new clients. The columns labeled "New Clients" include costs for all new service-eligible clients.

Exhibit E.4 presents a screenshot of the Summary worksheet. It provides a high-level summary of total costs by service across waivers. It displays a comparison of the total costs for each service currently and under the specified CFC scenario. It also calculates the total cost of these services to the General Fund and displays the share of General Fund costs for each service.

Exhibits E.5 through E.7 present screenshots of the Total Costs worksheet. (Because the worksheet is wide, we have split the image across several figures.) This worksheet displays the greatest detail on projected costs, with one cell for each combination of population and service. The formulas in each cell account for the inputs and assumptions chosen by the user and reflect the total cost of that population for the given scenario. The Total Costs worksheet serves as the source for summary tables and charts presented on the other worksheets.

Exhibits E.8 and E.9 present FTE totals by service and waiver/LTHH. FTEs are used to standardize the number of clients across services and waivers. Note that these figures come from information provided by HCPF and are hard-coded into the model. Because they reflect the number of individuals currently receiving services, the model does not treat them dynamically. These figures can be updated manually as needed.

Exhibits E.10 and E.11 present screenshots of the Mean Cost Per FTE worksheet. Note that current waiver clients provide the basis for projecting the costs of other populations. The Excel

workbook includes tabs for mean, median, and 25th percentile of current waiver costs per FTE. Because our illustration uses mean costs, Exhibits E.10 and E.11 are taken from the worksheet that displays those costs.

Exhibit E.3: The Expanded Summary Worksheet

Summary by Service & Population	Existing Costs				Costs Under CFC			Costs Under CFC		
	Federal		State General Fund		Federal			State General Fund		
Service	LTHH	Waiver	LTHH	Waiver	LTHH	Waiver	New Clients	LTHH	Waiver	New Clients
Adult Day Services		$ 5,374,298		$ 5,374,298	$ -	$ 5,374,298	$ -	$ -	$ 5,374,298	$ -
Alternative Care Facility (ACF)		$ 21,976,509		$ 21,976,509	$ -	$ 21,976,509	$ -	$ -	$ 21,976,509	$ -
Behavioral Management		$ 259		$ 259	$ -	$ 259	$ -	$ -	$ 259	$ -
Behavioral Therapies		$ 460,454		$ 460,454	$ -	$ 460,454	$ -	$ -	$ 460,454	$ -
Case Management		$ 518,126		$ 518,126	$ -	$ 518,126	$ -	$ -	$ 518,126	$ -
CHRP Habilitation		$ 2,186,007		$ 2,186,007	$ -	$ 2,186,007	$ -	$ -	$ 2,186,007	$ -
CHRP Professional Services		$ 5,797		$ 5,797	$ -	$ 5,797	$ -	$ -	$ 5,797	$ -
Client/Family/Caregiver Counseling		$ 29,591		$ 29,591	$ -	$ 29,591	$ -	$ -	$ 29,591	$ -
Community Connection Services		$ 378,328		$ 378,328	$ -	$ 378,328	$ -	$ -	$ 378,328	$ -
Community Transition Service (CTS)		$ 25,283		$ 25,283	$ -	$ 25,283	$ -	$ -	$ 25,283	$ -
Consumer Directed Attendant Support Services (CDASS)		$ 31,983,091		$ 31,983,091	$ 2,068,963	$ 58,313,097	$ 10,093,630	$ 1,625,614	$ 45,817,434	$ 7,930,710
Day Habilitation		$ 37,434,981		$ 37,434,981	$ -	$ 37,434,981	$ -	$ -	$ 37,434,981	$ -
Day Treatment		$ 283,127		$ 283,127	$ -	$ 283,127	$ -	$ -	$ 283,127	$ -
Dental Services		$ 1,765,664		$ 1,765,664	$ -	$ 1,765,664	$ -	$ -	$ 1,765,664	$ -
Expressive Therapy		$ 18,771		$ 18,771	$ -	$ 18,771	$ -	$ -	$ 18,771	$ -
Home Modification		$ 1,785,111		$ 1,785,111	$ -	$ 1,785,111	$ -	$ -	$ 1,785,111	$ -
Homemaker		$ 9,257,452		$ 9,257,452	$ 700,631	$ 17,045,791	$ 4,353,000	$ 550,496	$ 13,393,122	$ 3,420,214
In Home Support Services		$ 5,709,050		$ 5,709,050	$ 1,114,665	$ 22,797,445	$ 7,142,873	$ 875,808	$ 17,912,278	$ 5,612,257
Independent Living Skills Training (ILST)		$ 918,700		$ 918,700	$ -	$ 918,700	$ -	$ -	$ 918,700	$ -
Long-Term Home Health	$ 65,243,143	$ -	$ 65,243,143	$ -	$ 58,718,829	$ -	$ -	$ 58,718,829	$ -	$ -
Mental Health Counseling		$ 26,852		$ 26,852	$ -	$ 26,852	$ -	$ -	$ 26,852	$ -
Non-Medical Transportation		$ 10,820,990		$ 10,820,990	$ -	$ 10,820,990	$ -	$ -	$ 10,820,990	$ -
Palliative/Supportive Care Services		$ 2,052		$ 2,052	$ -	$ 2,052	$ -	$ -	$ 2,052	$ -
Personal Care		$ 46,297,916		$ 46,297,916	$ 1,981,708	$ 70,328,037	$ 12,226,404	$ 1,557,056	$ 55,257,743	$ 9,606,460
Personal Emergency Response Systems		$ 2,336,222		$ 2,336,222	$ -	$ 3,454,618	$ 517,946	$ -	$ 2,714,343	$ 406,957
Professional Services		$ 3,910,099		$ 3,910,099	$ -	$ 3,910,099	$ -	$ -	$ 3,910,099	$ -
Residential Habilitation		$ 105,494,578		$ 105,494,578	$ -	$ 105,494,578	$ -	$ -	$ 105,494,578	$ -
Respite		$ 3,647,055		$ 3,647,055	$ -	$ 3,647,055	$ -	$ -	$ 3,647,055	$ -
Specialized Medical Equipment and Supplies		$ 888,286		$ 888,286	$ -	$ 888,286	$ -	$ -	$ 888,286	$ -
Substance Abuse Counseling - Supported Living Program		$ 4,647,779		$ 4,647,779	$ -	$ 4,647,779	$ -	$ -	$ 4,647,779	$ -
Supported Employment		$ 3,751,150		$ 3,751,150	$ -	$ 3,751,150	$ -	$ -	$ 3,751,150	$ -
Vision Services		$ 302,214		$ 302,214	$ -	$ 302,214	$ -	$ -	$ 302,214	$ -
Total Cost	**$ 65,243,143**	**$ 302,235,792**	**$ 65,243,143**	**$ 302,235,792**	**$ 64,584,796**	**$ 378,591,050**	**$ 34,333,853**	**$ 63,327,803**	**$ 341,746,981**	**$ 26,976,599**

Exhibit E.4: The Summary Worksheet

Summary	Existing Costs		Costs Under CFC		
Service	**Federal**	**State General Fund**	**Federal**	**State General Fund**	**Share of General Fund**
Adult Day Services	$ 5,374,297.99	$ 5,374,297.99	$ 5,374,297.99	$ 5,374,297.99	1.2%
Alternative Care Facility (ACF)	$ 21,976,508.97	$ 21,976,508.97	$ 21,976,508.97	$ 21,976,508.97	5.1%
Behavioral Management	$ 258.94	$ 258.94	$ 258.94	$ 258.94	0.0%
Behavioral Therapies	$ 460,453.81	$ 460,453.81	$ 460,453.81	$ 460,453.81	0.1%
Case Management	$ 518,125.99	$ 518,125.99	$ 518,125.99	$ 518,125.99	0.1%
CHRP Habilitation	$ 2,186,006.79	$ 2,186,006.79	$ 2,186,006.79	$ 2,186,006.79	0.5%
CHRP Professional Services	$ 5,796.80	$ 5,796.80	$ 5,796.80	$ 5,796.80	0.0%
Client/Family/Caregiver Counseling	$ 29,591.10	$ 29,591.10	$ 29,591.10	$ 29,591.10	0.0%
Community Connection Services	$ 378,327.88	$ 378,327.88	$ 378,327.88	$ 378,327.88	0.1%
Community Transition Service (CTS)	$ 25,283.35	$ 25,283.35	$ 25,283.35	$ 25,283.35	0.0%
Consumer Directed Attendant Support Services (CDASS)	$ 31,983,091.24	$ 31,983,091.24	$ 70,475,690.80	$ 55,373,757.06	12.8%
Day Habilitation	$ 37,434,981.32	$ 37,434,981.32	$ 37,434,981.32	$ 37,434,981.32	8.7%
Day Treatment	$ 283,127.43	$ 283,127.43	$ 283,127.43	$ 283,127.43	0.1%
Dental Services	$ 1,765,664.04	$ 1,765,664.04	$ 1,765,664.04	$ 1,765,664.04	0.4%
Expressive Therapy	$ 18,771.49	$ 18,771.49	$ 18,771.49	$ 18,771.49	0.0%
Home Modification	$ 1,785,111.21	$ 1,785,111.21	$ 1,785,111.21	$ 1,785,111.21	0.4%
Homemaker	$ 9,257,451.80	$ 9,257,451.80	$ 22,099,422.00	$ 17,363,831.57	4.0%
In Home Support Services	$ 5,709,049.97	$ 5,709,049.97	$ 31,054,982.97	$ 24,400,343.76	5.6%
Independent Living Skills Training (ILST)	$ 918,699.70	$ 918,699.70	$ 918,699.70	$ 918,699.70	0.2%
Long-Term Home Health	**$ 65,243,143.06**	**$ 65,243,143.06**	**$ 58,718,828.75**	**$ 58,718,828.75**	**13.6%**
Mental Health Counseling	$ 26,851.94	$ 26,851.94	$ 26,851.94	$ 26,851.94	0.0%
Non-Medical Transportation	$ 10,820,990.22	$ 10,820,990.22	$ 10,820,990.22	$ 10,820,990.22	2.5%
Palliative/Supportive Care Services	$ 2,052.01	$ 2,052.01	$ 2,052.01	$ 2,052.01	0.0%
Personal Care	$ 46,297,915.91	$ 46,297,915.91	$ 84,536,148.72	$ 66,421,259.71	15.4%
Personal Emergency Response Systems	$ 2,336,221.56	$ 2,336,221.56	$ 3,972,563.68	$ 3,121,300.04	0.7%
Professional Services	$ 3,910,099.19	$ 3,910,099.19	$ 3,910,099.19	$ 3,910,099.19	0.9%
Residential Habilitation	$ 105,494,577.83	$ 105,494,577.83	$ 105,494,577.83	$ 105,494,577.83	24.4%
Respite	$ 3,647,055.23	$ 3,647,055.23	$ 3,647,055.23	$ 3,647,055.23	0.8%
Specialized Medical Equipment and Supplies	$ 888,285.96	$ 888,285.96	$ 888,285.96	$ 888,285.96	0.2%
Substance Abuse Counseling - Supported Living Program	$ 4,647,778.61	$ 4,647,778.61	$ 4,647,778.61	$ 4,647,778.61	1.1%
Supported Employment	$ 3,751,150.42	$ 3,751,150.42	$ 3,751,150.42	$ 3,751,150.42	0.9%
Vision Services	$ 302,213.57	$ 302,213.57	$ 302,213.57	$ 302,213.57	0.1%
Total Cost	**$ 367,478,935.31**	**$ 367,478,935.31**	**$ 477,509,698.72**	**$ 432,051,382.68**	

Exhibit E.5: Part 1 of the Total Costs Worksheet: Waivers and LTHH

	Waiver											Current LTHH
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CII**	**LTHH**
Adult Day Services	$ -	$ -	$ -	$ -	$ 106,262	$ 337,687	$ 7,997	$ 10,296,650	$ -	$ -	$ -	
Alternative Care Facility (ACF)	$ -	$ -	$ -	$ -	$ -	$ 16,168,632	$ -	$ 27,784,386	$ -	$ -	$ -	
Behavioral Management	$ -	$ -	$ -	$ -	$ 518	$ -	$ -	$ -	$ -	$ -	$ -	
Behavioral Therapies	$ -	$ 920,908	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Case Management	$ 1,030,726	$ -	$ -	$ 5,526	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
CHRP Habilitation	$ -	$ -	$ -	$ 4,372,014	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
CHRP Professional Services	$ -	$ -	$ -	$ 11,594	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Client/Family/Caregiver Counseling	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 59,182	
Community Connection Services	$ -	$ -	$ 756,656	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Community Transition Service (CTS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,567	$ -	$ -	$ -	
Consumer Directed Attendant Support Services (CDASS)	$ 5,062,642	$ 327,783	$ 1,479,901	$ 536,305	$ 576,809	$ 999,753	$ 161,266	$ 62,966,430	$ 12,114,486	$ 19,492,239	$ 412,917	
Day Habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,250,996	$ 56,618,966	$ -	
Day Treatment	$ -	$ -	$ -	$ -	$ 566,255	$ -	$ -	$ -	$ -	$ -	$ -	
Dental Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,184,583	$ 2,346,745	$ -	
Expressive Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 37,543	
Home Modification	$ -	$ -	$ 106,904	$ -	$ 13,440	$ 87,401	$ -	$ 3,212,073	$ 150,404	$ -	$ -	
Homemaker	$ 2,285,875	$ 148,000	$ 567,608	$ 242,151	$ 260,440	$ 2,184,722	$ 77,218	$ 14,219,031	$ 1,466,326	$ 8,801,103	$ 186,440	
In Home Support Services	$ 2,101,361	$ 235,460	$ 1,063,073	$ 385,249	$ 414,345	$ 4,076,640	$ 115,844	$ 9,316,739	$ 8,702,328	$ 14,002,067	$ 296,615	
Independent Living Skills Training (ILST)	$ -	$ -	$ -	$ -	$ 1,837,399	$ -	$ -	$ -	$ -	$ -	$ -	
Long-Term Home Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 130,486,286.12
Mental Health Counseling	$ -	$ -	$ -	$ -	$ 53,704	$ -	$ -	$ -	$ -	$ -	$ -	
Non-Medical Transportation	$ -	$ -	$ -	$ -	$ 199,309	$ 1,355,039	$ 9,644	$ 6,990,048	$ 3,715,969	$ 9,371,972	$ -	
Palliative/Supportive Care Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,104	
Personal Care	$ 6,465,509	$ 418,613	$ 150,943	$ 684,916	$ 444,085	$ 4,215,784	$ 411,907	$ 84,181,735	$ 3,191,378	$ 24,893,574	$ 527,337	
Personal Emergency Response Systems	$ 277,402	$ 17,961	$ 81,089	$ 29,386	$ 9,110	$ 219,418	$ 9,453	$ 4,405,548	$ 28,915	$ 1,068,054	$ 22,625	
Professional Services	$ -	$ -	$ 3,060,302	$ -	$ -	$ -	$ -	$ -	$ 867,502	$ 3,892,395	$ -	
Residential Habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 210,989,156	$ -	
Respite	$ -	$ -	$ 2,426,536	$ -	$ 56,646	$ 34,112	$ -	$ 769,983	$ 3,936,754	$ -	$ 70,081	
Specialized Medical Equipment and Supplies	$ -	$ -	$ 68,767	$ -	$ 4,847	$ 331,781	$ -	$ 1,104,821	$ 22,342	$ 244,014	$ -	
Substance Abuse Counseling - Supported Living Program	$ -	$ -	$ -	$ -	$ 9,295,557	$ -	$ -	$ -	$ -	$ -	$ -	
Supported Employment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,932,823	$ 5,569,478	$ -	
Vision Services	$ -	$ -	$ 4,251	$ -	$ -	$ -	$ -	$ -	$ 218,637	$ 381,539	$ -	

Exhibit E.6: Part 2 of the Total Costs worksheet: Waitlists

	Waitlist										
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CLLI**
Adult Day Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Alternative Care Facility (ACF)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Behavioral Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Behavioral Therapies	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Case Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CHRP Habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CHRP Professional Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Client/Family/Caregiver Counseling	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Community Connection Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Community Transition Service (CTS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Consumer Directed Attendant Support Services (CDASS)	$ 598,561	$ 612,062	$ -	$ -	$ 126,013	$ -	$ -	$ -	$ 1,098,112	$ 8,798,398	$ 40,504
Day Habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Day Treatment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dental Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Expressive Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home Modification	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Homemaker	$ 270,261	$ 276,357	$ -	$ -	$ 56,897	$ -	$ -	$ -	$ 130,712	$ 3,972,638	$ 18,288
In Home Support Services	$ 237,485	$ 439,669	$ -	$ -	$ 90,520	$ -	$ -	$ -	$ 788,819	$ 6,320,247	$ 29,096
Independent Living Skills Training (ILST)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Long-Term Home Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Mental Health Counseling	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Non-Medical Transportation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Palliative/Supportive Care Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Personal Care	$ 764,423	$ 781,666	$ -	$ -	$ 92,607	$ -	$ -	$ -	$ 284,672	$ 11,236,450	$ 51,728
Personal Emergency Response Systems	$ 32,797	$ 33,537	$ -	$ -	$ 1,801	$ -	$ -	$ -	$ 2,555	$ 482,098	$ 2,219
Professional Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Residential Habilitation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Respite	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Specialized Medical Equipment and Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Substance Abuse Counseling - Supported Living Program	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supported Employment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vision Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Exhibit E.7: Part 3 of the Total Costs worksheet: Allocations and Totals

Service	LTHH Allocation	Non-Waiver, Non-Waitlist	Total
Adult Day Services	$ -	$ -	$ 10,748,595.99
Alternative Care Facility (ACF)	$ -	$ -	$ 43,953,017.94
Behavioral Management	$ -	$ -	$ 517.88
Behavioral Therapies	$ -	$ -	$ 920,907.62
Case Management	$ -	$ -	$ 1,036,251.98
CHRP Habilitation	$ -	$ -	$ 4,372,013.57
CHRP Professional Services	$ -	$ -	$ 11,593.60
Client/Family/Caregiver Counseling	$ -	$ -	$ 59,182.20
Community Connection Services	$ -	$ -	$ 756,655.76
Community Transition Service (CTS)	$ -	$ -	$ 50,566.70
Consumer Directed Attendant Support Services (CDASS)	$ 3,694,577.12	$ 6,750,689.06	$ 125,849,447.86
Day Habilitation	$ -	$ -	$ 74,869,962.64
Day Treatment	$ -	$ -	$ 566,254.85
Dental Services	$ -	$ -	$ 3,531,328.09
Expressive Therapy	$ -	$ -	$ 37,542.99
Home Modification	$ -	$ -	$ 3,570,222.41
Homemaker	$ 1,251,126.90	$ 3,048,059.69	$ 39,463,253.57
In Home Support Services	$ 1,990,473.68	$ 4,849,294.34	$ 55,455,326.72
Independent Living Skills Training (ILST)	$ -	$ -	$ 1,837,399.41
Long-Term Home Health	$ 117,437,657.51	$ -	$ 117,437,657.51
Mental Health Counseling	$ -	$ -	$ 53,703.89
Non-Medical Transportation	$ -	$ -	$ 21,641,980.44
Palliative/Supportive Care Services	$ -	$ -	$ 4,104.01
Personal Care	$ 3,538,763.41	$ 8,621,317.38	$ 150,957,408.43
Personal Emergency Response Systems	$ -	$ 369,896.09	$ 7,093,863.72
Professional Services	$ -	$ -	$ 7,820,198.38
Residential Habilitation	$ -	$ -	$ 210,989,155.65
Respite	$ -	$ -	$ 7,294,110.46
Specialized Medical Equipment and Supplies	$ -	$ -	$ 1,776,571.92
Substance Abuse Counseling - Supported Living Program	$ -	$ -	$ 9,295,557.22
Supported Employment	$ -	$ -	$ 7,502,300.84
Vision Services	$ -	$ -	$ 604,427.14
			$ 909,561,081.40

Exhibit E.8: Part 1 of the FTE Totals by Service Worksheet: Waivers and LTHH

	Waiver											LTHH
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CII**	**State**
Adult Day Services	0	0	0	0	21	80	1	1870	0	0	0	0
Alternative Care Facility (ACF)	0	0	0	0	0	1261	0	2809	0	0	0	0
Behavioral Management	11	1	3	1	1	13	0	104	27	43	1	0
Behavioral Therapies	225	73	66	24	26	252	7	2087	538	866	18	0
Case Management	1125	0	0	17	0	0	0	0	0	0	0	0
CHRP Habilitation	0	0	0	119	0	0	0	0	0	0	0	0
CHRP Professional Services	0	0	0	3	0	0	0	0	0	0	0	0
Client/Family/Caregiver Counseling	0	0	0	0	0	0	0	0	0	0	92	0
Community Connection Services	0	0	128	0	0	0	0	0	0	0	0	0
Community Transition Service (CTS)	0	0	0	0	0	0	0	27	0	0	0	0
Consumer Directed Attendant Support Services (CDASS)	169	11	49	18	19	67	5	2099	404	650	14	18
Day Habilitation	0	0	0	0	0	0	0	0	2692	3894	0	0
Day Treatment	0	0	0	0	36	0	0	0	0	0	0	0
Dental Services	0	0	0	0	0	0	0	0	1805	3773	0	0
Expressive Therapy	0	0	0	0	0	0	0	0	0	0	59	0
Home Modification	0	0	34	0	3	15	0	613	36	0	0	0
Homemaker	562	36	187	60	64	754	19	5028	831	2166	46	154
In Home Support Services	65	7	33	12	13	126	4	300	269	433	9	6
Independent Living Skills Training (ILST)	112	7	33	12	102	126	4	1043	269	433	9	0
Long-Term Home Health	0	0	0	0	0	0	0	0	0	0	0	6157
Mental Health Counseling	56	4	16	6	60	63	2	522	135	217	5	0
Non-Medical Transportation	562	36	164	60	33	692	6	2874	2513	3934	46	0
Palliative/Supportive Care Services	0	0	0	0	0	0	0	0	0	0	20	0
Personal Care	562	36	36	60	63	682	36	10435	1297	2166	46	154
Personal Emergency Response Systems	506	33	148	54	19	457	17	9284	77	1949	41	0
Professional Services	0	0	297	0	0	0	0	0	297	1316	0	0
Residential Habilitation	0	0	0	0	0	0	0	0	0	4331	0	0
Respite	450	29	329	48	12	22	14	393	914	1732	59	49
Specialized Medical Equipment and Supplies	0	0	144	0	11	519	0	1778	72	522	0	0
Substance Abuse Counseling - Supported Living Program	0	0	0	0	128	0	0	0	0	0	0	0
Supported Employment	0	0	0	0	0	0	0	0	612	953	0	0
Vision Services	0	0	2	0	0	0	0	0	683	1657	0	0

Exhibit E.9: Part 2 of the "FTE Totals by Service": Waitlists, LTHH Allocation, and Non-Waiver, Non-Waitlist Take-up

	Waitlist											LTHH Allocation	Non-waiver Non-waitlist
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CLLI**	**State**	**Take-Up**
Adult Day Services	0	0	0	0	5	0	0	0	0	0	0	0	0
Alternative Care Facility (ACF)	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Management	1	1	0	0	0	0	0	0	2	20	0	0	15
Behavioral Therapies	27	96	0	0	6	0	0	0	49	391	2	0	300
Case Management	127	0	0	0	0	0	0	0	0	0	0	0	0
CHRP Habilitation	0	0	0	0	0	0	0	0	0	0	0	0	0
CHRP Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	0
Client/Family/Caregiver Counseling	0	0	0	0	0	0	0	0	0	0	9	0	0
Community Connection Services	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Transition Service (CTS)	0	0	0	0	0	0	0	0	0	0	0	0	0
Consumer Directed Attendant Support Services (CDASS)	20	20	0	0	4	0	0	0	37	293	1	123.14	225
Day Habilitation	0	0	0	0	0	0	0	0	240	1737	0	0	0
Day Treatment	0	0	0	0	7	0	0	0	0	0	0	0	0
Dental Services	0	0	0	0	0	0	0	0	162	1689	0	0	0
Expressive Therapy	0	0	0	0	0	0	0	0	0	0	6	0	0
Home Modification	0	0	0	0	1	0	0	0	3	0	0	0	0
Homemaker	67	68	0	0	14	0	0	0	74	978	5	307.85	750
In Home Support Services	7	14	0	0	3	0	0	0	24	196	1	61.57	150
Independent Living Skills Training (ILST)	13	14	0	0	21	0	0	0	24	196	1	0	150
Long-Term Home Health	0	0	0	0	0	0	0	0	0	0	0	5541.3	0
Mental Health Counseling	7	7	0	0	12	0	0	0	12	98	0	0	75
Non-Medical Transportation	67	68	0	0	7	0	0	0	224	1757	5	0	750
Palliative/Supportive Care Services	0	0	0	0	0	0	0	0	0	0	0	0	0
Personal Care	67	68	0	0	13	0	0	0	116	978	5	307.85	750
Personal Emergency Response Systems	60	61	0	0	4	0	0	0	7	880	4	0	675
Professional Services	0	0	0	0	0	0	0	0	26	589	0	0	0
Residential Habilitation	0	0	0	0	0	0	0	0	0	1929	0	0	0
Respite	53	54	0	0	2	0	0	0	82	782	6	123.14	600
Specialized Medical Equipment and Supplies	0	0	0	0	2	0	0	0	6	231	0	0	0
Substance Abuse Counseling - Supported Living Program	0	0	0	0	26	0	0	0	0	0	0	0	0
Supported Employment	0	0	0	0	0	0	0	0	55	427	0	0	0
Vision Services	0	0	0	0	0	0	0	0	61	744	0	0	0

Exhibit E.10: Part 1 of the Mean Cost worksheet: Waivers and LTHH/New

	Waiver											LTHH &
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CII**	**New**
Adult Day Services					$ 5,080	$ 4,243	$ 7,997	$ 5,508				$ 7,997
Alternative Care Facility (ACF)						$ 12,822		$ 9,892				$ 12,822
Behavioral Management					$ 518							$ 518
Behavioral Therapies		$ 12,644										$ 12,644
Case Management	$ 916			$ 325								$ 916
CHRP Habilitation				$ 36,688								$ 36,688
CHRP Professional Services				$ 3,865								$ 3,865
Client/Family/Caregiver Counseling											$ 645	$ 645
Community Connection Services			$ 5,908									$ 5,908
Community Transition Service (CTS)								$ 1,844				$ 1,844
Consumer Directed Attendant Support Services (CDASS)						$ 14,940		$ 30,003				$ 30,003
Day Habilitation									$ 6,780	$ 14,538		$ 14,538
Day Treatment					$ 15,876							$ 15,876
Dental Services									$ 656	$ 622		$ 656
Expressive Therapy											$ 638	$ 638
Home Modification			$ 3,144		$ 4,480	$ 6,028		$ 5,242	$ 4,178			$ 6,028
Homemaker			$ 3,035			$ 2,899	$ 4,064	$ 2,828	$ 1,765			$ 4,064
In Home Support Services	$ 32,329							$ 31,073				$ 32,329
Independent Living Skills Training (ILST)					$ 17,984							$ 17,984
Long-Term Home Health												$ 21,193
Mental Health Counseling					$ 895							$ 895
Non-Medical Transportation					$ 6,117	$ 1,958	$ 1,543	$ 2,432	$ 1,479	$ 2,382		$ 6,117
Palliative/Supportive Care Services											$ 202	$ 202
Personal Care			$ 4,212		$ 7,058	$ 6,183	$ 11,495	$ 8,068	$ 2,461			$ 11,495
Personal Emergency Response Systems					$ 486	$ 481	$ 548	$ 475	$ 375			$ 548
Professional Services			$ 10,295						$ 2,926	$ 2,957		$ 10,295
Residential Habilitation										$ 48,714		$ 48,714
Respite			$ 7,379		$ 4,720	$ 1,587		$ 1,962	$ 4,308		$ 1,189	$ 7,379
Specialized Medical Equipment and Supplies			$ 479		$ 434	$ 640		$ 621	$ 310	$ 467		$ 640
Substance Abuse Counseling - Supported Living Program					$ 72,527							$ 72,527
Supported Employment									$ 3,159	$ 5,847		$ 5,847
Vision Services			$ 2,126						$ 320	$ 230		$ 320

Exhibit E.11: Part 2 of the Mean Cost worksheet: Waitlists

	Waitlist										
Service	**CHCBS**	**CWA**	**CES**	**CHRP**	**BI**	**CMHS**	**PLWA**	**EBD**	**SLS**	**DD**	**CLLI**
Adult Day Services	$ 7,997	$ 7,997	$ 7,997	$ 7,997	$ 5,080	$ 4,243	$ 7,997	$ 5,508	$ 7,997	$ 7,997	$ 7,997
Alternative Care Facility (ACF)	$ 12,822	$ 12,822	$ 12,822	$ 12,822	$ 12,822	$ 12,822	$ 12,822	$ 9,892	$ 12,822	$ 12,822	$ 12,822
Behavioral Management	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518	$ 518
Behavioral Therapies	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644	$ 12,644
Case Management	$ 916	$ 916	$ 916	$ 325	$ 916	$ 916	$ 916	$ 916	$ 916	$ 916	$ 916
CHRP Habilitation	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688	$ 36,688
CHRP Professional Services	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865	$ 3,865
Client/Family/Caregiver Counseling	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645	$ 645
Community Connection Services	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908	$ 5,908
Community Transition Service (CTS)	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844	$ 1,844
Consumer Directed Attendant Support Services (CDASS)	$ 30,003	$ 30,003	$ 30,003	$ 30,003	$ 30,003	$ 14,940	$ 30,003	$ 30,003	$ 30,003	$ 30,003	$ 30,003
Day Habilitation	$ 14,538	$ 14,538	$ 14,538	$ 14,538	$ 14,538	$ 14,538	$ 14,538	$ 14,538	$ 6,780	$ 14,538	$ 14,538
Day Treatment	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876	$ 15,876
Dental Services	$ 656	$ 656	$ 656	$ 656	$ 656	$ 656	$ 656	$ 656	$ 656	$ 622	$ 656
Expressive Therapy	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638	$ 638
Home Modification	$ 6,028	$ 6,028	$ 3,144	$ 6,028	$ 4,480	$ 6,028	$ 6,028	$ 5,242	$ 4,178	$ 6,028	$ 6,028
Homemaker	$ 4,064	$ 4,064	$ 3,035	$ 4,064	$ 4,064	$ 2,899	$ 4,064	$ 2,828	$ 1,765	$ 4,064	$ 4,064
In Home Support Services	$ 32,329	$ 32,329	$ 32,329	$ 32,329	$ 32,329	$ 32,329	$ 32,329	$ 31,073	$ 32,329	$ 32,329	$ 32,329
Independent Living Skills Training (ILST)	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984	$ 17,984
Long-Term Home Health											
Mental Health Counseling	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895	$ 895
Non-Medical Transportation	$ 6,117	$ 6,117	$ 6,117	$ 6,117	$ 6,117	$ 1,958	$ 1,543	$ 2,432	$ 1,479	$ 2,382	$ 6,117
Palliative/Supportive Care Services	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202	$ 202
Personal Care	$ 11,495	$ 11,495	$ 4,212	$ 11,495	$ 7,058	$ 6,183	$ 11,495	$ 8,068	$ 2,461	$ 11,495	$ 11,495
Personal Emergency Response Systems	$ 548	$ 548	$ 548	$ 548	$ 486	$ 481	$ 548	$ 475	$ 375	$ 548	$ 548
Professional Services	$ 10,295	$ 10,295	$ 10,295	$ 10,295	$ 10,295	$ 10,295	$ 10,295	$ 10,295	$ 2,926	$ 2,957	$ 10,295
Residential Habilitation	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714	$ 48,714
Respite	$ 7,379	$ 7,379	$ 7,379	$ 7,379	$ 4,720	$ 1,587	$ 7,379	$ 1,962	$ 4,308	$ 7,379	$ 1,189
Specialized Medical Equipment and Supplies	$ 640	$ 640	$ 479	$ 640	$ 434	$ 640	$ 640	$ 621	$ 310	$ 467	$ 640
Substance Abuse Counseling - Supported Living Program	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527	$ 72,527
Supported Employment	$ 5,847	$ 5,847	$ 5,847	$ 5,847	$ 5,847	$ 5,847	$ 5,847	$ 5,847	$ 3,159	$ 5,847	$ 5,847
Vision Services	$ 320	$ 320	$ 2,126	$ 320	$ 320	$ 320	$ 320	$ 320	$ 320	$ 230	$ 320